State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Oregon

Summary: In 2011, Oregon was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Oregon Health Authority has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., June 13, 2012. You may submit comments on this proposal to OR-MedicareMedicaidCoordination@cms.hhs.gov.

State of Oregon
Oregon Health Authority

Proposal to the Centers for Medicare and Medicaid Services

Medicare/Medicaid Alignment Demonstration to Integrate Care for Individuals who are Dually Eligible

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May 11, 2012

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A. Executive Summary

Since it was established in 1994, the Oregon Health Plan (OHP) Waiver Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, thereby saving the federal and state government more than $15 billion over the life of the 1115 Demonstration. Oregon is requesting approval from the Centers for Medicare and Medicaid Services (CMS) to implement its Health System Transformation reforms; specifically via a waiver renewal and amendment for Medicaid flexibilities, and via participation in a CMS demonstration as described in this document, which constitutes Oregon's proposal to CMS to integrate and coordinate care for individuals who are dually eligible for Medicare and Medicaid. With these requests, Oregon seeks to build on its long history of demonstrated leadership in health reform and to meet three key policy objectives:

1. Transform Oregon's delivery system to focus on prevention, integration, and coordination across the continuum of health care to improve outcomes and bend the cost curve;
2. Promote better health, better care, and lower costs; and
3. Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.

Oregon's roughly 60,000 individuals dually enrolled in Medicare and Medicaid have complex care needs, but are currently served by a fragmented delivery system that creates coordination challenges and access barriers for individuals, their families and care givers. This population has some of the highest needs and costs; for example, although only 18% of Medicare fee-for-service beneficiaries are also eligible for Medicaid, their care accounts for 31% of Medicare fee-for-service expenditures.[1] Further, a significant proportion of individuals receiving long term care (LTC) services are also dually eligible, making coordination between the LTC and the health care systems critical, but currently challenging.

Oregon has long been a leader among states in providing Medicaid-funded LTC in community rather than institutional settings, and recognizes the importance of coordinating Medicare hospital, physician, prescription drug and other acute care services for individuals with Medicaid-funded LTC services in home, community, and institutional settings.

This proposal envisions a system anchored by the creation of new Coordinated Care Organizations (CCOs) that focus on integrated and coordinated patient-centered care that emphasizes prevention and makes the individual a partner in care management. The first CCOs in Oregon will begin operation in August 2012, with later waves coming on throughout the fall of 2012. CCOs are community-based organizations governed by a partnership among those sharing in financial risk, providers of care, and community members. A CCO will have a global budget that grows at a fixed rate per capita, and will be responsible for the integration and coordination of physical, behavioral and oral health care for individuals eligible for Medicaid as well as those dually eligible for both Medicaid and Medicare (either through this demonstration or through an affiliated Medicare Advantage plan). CCOs will be the single point of accountability for the health quality and outcomes for the enrolled Medicaid and dually eligible populations they serve. They will also be given the financial flexibility within available resources to achieve the best possible outcomes for their membership. Lastly, although Medicaid-funded LTC services are excluded from CCO global budgets, CCOs will share accountability with the LTC system for ensuring the care delivered to individuals receiving LTC services is coordinated and aligned.

[1] Medicare Payment Advisory Committee, "A Data Book: Health Care Spending and the Medicare Program," June 2011, available at http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf (accessed February 29, 2012). The statistics cited are national figures from 2007.

This demonstration builds off the overall CCO model, and allows Medicare funding to be integrated with Medicaid funding in CCOs for dually eligible individuals, and will allow plans to better coordinate care and align administrative processes, creating a more seamless system for their dually eligible members. If this proposal is approved by CMS, and mutually agreeable terms are reached, Oregon's demonstration will start in January 2014 rather than 2013, to give CCOs time to get established and ensure that the terms of the demonstration are known before CCOs must decide whether to apply. Participation in the demonstration will be voluntary for CCOs, but we expect that most CCOs will wish to participate if the terms are favorable.

With these reforms, Oregon will be well-positioned to provide better care to those currently enrolled and improved access to better care as the Affordable Care Act adds millions of new Medicaid enrollees across the country in 2014. As Oregon implements its most ambitious health care transformation plan to date, focusing on person-centered, integrated, coordinated care and alignment of incentives, we expect to demonstrate that such innovations can improve health outcomes, improve the quality of care and care experience, protect individuals' rights and hold costs to a sustainable, fixed rate of per capita cost growth.

Target Population	All full benefit Medicare-Medicaid enrollees
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	59,000 (Average Monthly Caseload CY2010) 68,000 (Forecasted Caseload in January 2014)
Total Number of Beneficiaries Eligible for Demonstration	All but enrollees in the Program of All-Inclusive Care for the Elderly (PACE)
Geographic Service Area	Statewide
Summary of Covered Benefits	• Medicaid State Plan/1115 waiver services including physical, behavioral, and oral health services, excluding long term care • Medicare Parts A, B, and D services • Additional services related to care management and coordination
Financing Model	Capitated, per the financial alignment model in the July 8, 2011 State Medicaid Director's letter.
Summary of Stakeholder Engagement/Input	• 8 stakeholder workgroup meetings specifically related to Medicare/Medicaid integration (Aug. 2011-Jan. 2012) • 8 community meetings (Oct, 2011) • 11 total listening sessions with dually eligible individuals (June/Dec. 2011) • Meetings with individual stakeholder groups (ongoing) • More than 60 board meetings, workgroups, Medicaid Advisory Committee meetings, and opportunities for public input to the Oregon Health Policy Board to develop overarching CCO Implementation Proposal (2011-Jan. 2012) • 39 day public comment period on the draft proposal, with 20 comments received, 2 public meetings related to the draft proposal, and several workgroups/stakeholder meetings (March – April 2012)
Proposed Implementation Date(s)	January 2014

B. Background

Vision and rationale

A vision of transformation, building on a mature foundation

Oregon's Health System Transformation, the next stage of innovation for Oregon's mature managed care system, has the promise to improve health outcomes and bend the health cost curve at the same time. Unlike many states, Oregon's managed care system is 30 years along in this process, with the following achievements:

- comparatively low costs due, in part, to relatively efficient and locally managed care;
- cost savings of $15 billion per federal evaluations of Oregon's 1115 waiver/Medicaid budget neutrality since 1989;
- low reliance on institutional care for those needing long term supports and services;
- comparatively low hospitalization rates; and
- among the highest rates of managed care both in Medicaid (78% overall, 61% dually eligible) and Medicare (40% overall, 47% dually eligible).[2]

Oregon's Medicaid and Medicare Advantage health plans are largely local or regional, and a significant portion of individuals who are dually eligible for both programs are enrolled in plans that take steps to coordinate Medicare and Medicaid benefits, such as Medicare Advantage Special Needs Plans. In delivery of LTC,[3] Oregon is a national leader; in recent rankings,[4] Oregon was ranked third in the nation for delivery of LTC services – in part due to Oregon's successes in providing LTC services to individuals in less restrictive, lower-cost home and community based settings as opposed to nursing facilities (roughly 80% and 20%, respectively).

Although Oregon has achieved considerable success, the state still faces cost growth rates that are unsustainable. Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven insufficient in improving health outcomes and containing costs simultaneously. Health System Transformation will increase the value of resources invested in health care by following a fourth pathway: rather than simply reducing expenditures into an inefficient system, Oregon will change the delivery system for better efficiency, value, and health outcomes.

Health System Transformation is the next step forward for Oregon's health reform efforts that began in 1989 with then Senate President (and current Governor) Dr. John Kitzhaber's creation of the Oregon Health Plan (OHP) and Oregon's innovative Section 1115 Demonstration which implemented Oregon's

[2] Medicare - Kaiser Family Foundation analysis of the CMS State/County Market Penetration file, released in March 2011. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=329&cat=6 (accessed March 1, 2012).
[3] Note: in this proposal, the terms "Medicaid-funded LTC" and "LTC" are used to refer to both Nursing Facility care and Home and Community Based Services (HCBS) for individuals who are aged or physically disabled and require services and supports for their activities of daily living. Services for individuals who are intellectually or developmentally disabled (I/DD) or who require long term care/residential treatment related to mental health or chemical dependency are specifically identified as such, and are not referred to as LTC in this proposal.
[4] Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." September 2011.

approach to accountable allocation of health resources using the Prioritized List of Health Services. Now, in 2012, Oregon is uniquely poised to implement the comprehensive reforms that will improve health outcomes and reduce the rate of cost growth. Health System Transformation in Oregon is already underway with the implementation of the state's Patient-Centered Primary Care Home (PCPCH, also known as medical home or health home) initiative; more than 150 clinics have applied for recognition and 130 have already been recognized as PCPCHs to date. Oregon has legislative support, strong leadership from the Governor, a well-respected oversight board (the Oregon Health Policy Board (OHPB)), and supportive stakeholders including plans, providers, advocates, and others. Stakeholders have been involved in every stage of development of Health System Transformation strategies and policies – beginning with the efforts of the Health Policy Commission, which launched in 2003, and continued with the Health Fund Board (2007-2009) and the current Health Policy Board (2009-present), with participation by hundreds of individuals on workgroups, committees, and boards, and input and public comment from literally thousands of Oregonians.

Oregon's Health System Transformation will implement reforms for Oregonians receiving Medicaid benefits. Among the individuals most in need of services and coordination of services are those dually eligible for Medicare and Medicaid. In 2007, Oregon's dually eligible population accounted for about $1.8 billion in combined Medicare and Medicaid annual spending.[5] For those Oregonians dually eligible for both Medicaid and Medicare, Oregon proposes incorporating the CMS Financial Alignment Demonstration into its overall transformation approaches.

The overarching policy goal of Oregon's Health System Transformation is to achieve better health, better healthcare, and lower costs for Oregonians. However, the true promise of Oregon's CCO model is demonstrating for the nation, that such goals are achievable at the state level. Oregon's experience shows that, while managed care approaches can yield savings and begin to control costs, they are not sufficient to reduce health care cost growth to a level that is sustainable over the long term. To substantially bend the cost curve, fundamental delivery system reform will be needed, such as the model that Oregon is pursuing to empower local communities and pay for health outcomes rather than encounters. Demonstrating on-the-ground solutions that sustainably improve client experience and outcomes and contain costs will be particularly important as the Affordable Care Act adds millions of new Medicaid enrollees across the country in 2014. Oregon sees its Health System Transformation as starting with the Medicaid population, including dually eligible individuals, but ultimately as having the potential to transform health care delivery across the various markets in the state, including the commercial market. Oregon plans to expand delivery system reforms to the Oregon Educational Benefits Board (OEBB) and Public Employee Benefits Board (PEBB) and potentially beyond those programs through the Oregon Health Insurance Exchange in the years to come.

Health System Transformation: Coordinated Care Organizations

In June 2011, the Oregon Legislature and Governor John Kitzhaber called for the creation of Coordinated Care Organizations (CCOs) in House Bill (HB) 3650, which aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the finance and delivery of health care. In February 2012, the legislature approved the OHPB's CCO Implementation Proposal in Senate Bill (SB) 1580. Essential elements of Health System Transformation and CCOs are:

- Person-centered, evidence-based care that is effectively coordinated and integrated;

[5] Includes individuals both fully dually eligible and partially dually eligible, but does not include Medicaid buy-in payments for Part B premiums. Source: Centers for Medicare and Medicaid Services, "Medicare-Medicaid Enrollee State Profile | Oregon", forthcoming.

- Community-based delivery systems with local accountability for health and resource allocation;
- A global Medicaid budget tied to a sustainable rate of per-capita growth, with alternative payment methodologies that reward for health outcomes and not merely encounters;
- Transparency and accountability for cost and outcomes; and
- Shared accountability for LTC.

Integration and coordination: Although Oregon's Medicaid managed care organizations, mental health organizations and dental care organizations, and Oregon's Medicare Advantage plans have achieved some successes in better managing care and reducing costs for individuals who are dually eligible, the current structure limits their ability to maximize efficiency and value through effective integration, coordination, and person-centered care. Each entity is paid separately by the state and/or CMS and focuses on a single aspect of an individual's overall health. The current payment system does not provide strong incentives for the prevention or disease management services that can improve health and stabilize chronic conditions, and thus also lower costs. Further, navigating several different plans to receive services can be confusing and difficult for the individuals served and thus work against patient engagement and improved health.

By integrating and coordinating physical, behavioral, and oral care via integrating Medicare and Medicaid programs for individuals who are dually eligible, CCOs will work to better meet these individuals' myriad needs. One component of this integration will be the use of new non-traditional health workers, such as community health workers and peer wellness specialists, who can take person-centered care outside the clinical setting and beyond the monthly appointment approach to managing chronic conditions, and ultimately support individuals to become active partners in improving their own health. Integration and coordination are particularly relevant for the significant proportion of dually eligible individuals with both chronic conditions and behavioral health needs, who often face barriers to care to meets their interrelated needs. PCPCHs and other intensive needs care coordinators will actively coordinate care and help to ensure that individuals access the supports needed to better manage their own health.

Lastly, integration of health care silos, including Medicare and Medicaid, will address administrative inefficiencies and poorly aligned financial incentives. Administrative and organizational alignment will help to create an integrated and seamless system for individuals, with a single set of materials, processes, and benefits. Integrating these programs also resets incentives to invest in more person-centered care. For example, investing in coordination under the Medicaid program would typically result in savings to the Medicare program, but, with integration of Medicare and Medicaid, savings are achieved within the same health plan.

Community-based systems with local accountability: Oregon's Health System Transformation envisions that CCOs will be flexible in addressing community needs and will be held accountable, not just to the OHA, but to local stakeholders, for meeting those needs. CCOs will partner with their local public health authority, hospital system, and local mental health authority to develop a shared community needs assessment that includes a focus on health disparities in the community, and will take into account the needs of individuals served by Oregon's Medicaid-funded LTC system and other social service systems. The assessment will drive the CCOs' community health improvement planning and provider network and capacity development, such that provider networks are organized to be responsive to community needs and to address health disparities.

CCO organizational structures will vary to meet the needs of the individuals and communities they will serve. OHA criteria for CCO governing boards support the creation of a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined by achieving the goals of the Triple Aim. A CCO's governance structure must include a majority interest consisting of persons that share in the financial risk of the organization.[6] In addition, each CCO will convene a community advisory council that includes representatives of the community and of county government, but with consumers making up the majority of membership. This council will meet regularly to ensure that the health care needs of the consumers and the community are being addressed by the CCO and will lead the development of a community health assessment and a community health improvement plan for addressing health disparities and improving community health. The community advisory council will send one member to the CCO governing board.

Payment reform and controlling cost growth: Oregon's Health System Transformation envisions paying health plans and providers innovatively to create financial incentives that are aligned to achieve the Triple Aim. CCO global budgets are designed to cover the broadest range of funded services for the most individuals possible to change the course of unsustainable costs and insufficient return on investment in terms of health outcomes. CCOs will be responsible for providing services that are currently provided under Medicare for dually eligible individuals (through this demonstration) and through Medicaid managed care in addition to Medicaid programs and services that have previously been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care. After establishing the baseline global budget, Oregon proposes to contain CCO global budgets to a sustainable, fixed rate of per capita cost growth and will work with CMS to develop an appropriate methodology. CCOs will also be encouraged to align financial and other incentives across provider types and settings of care by using alternative payment methodologies that, for example, pay for outcomes rather than services, or bundle reimbursement for an episode of care.

Transparency and accountability: CCOs will be accountable for outcomes associated with better health, better quality of care, and more sustainable costs. CCOs' performance will be assessed via publicly reported metrics and contractual quality measures that function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery. Accountability metrics and performance expectations for CCOs will be introduced in graduated phases to allow CCOs to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards. Once CCO metrics are phased in, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

Shared accountability for LTC: Oregon's successes in serving individuals eligible for Medicaid-funded LTC in home and community based settings is due in large part to the involvement by stakeholders, advocates, and LTC providers and the local state field offices and Area Agencies on Aging (AAA), which in some regions are contracted to provide Medicaid services. Given that Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the state, Oregon sought extensive input from stakeholders in developing its key strategies for coordination between

[6] In the context of CCO governance, an entity has financial risk when it assumes risk for health care expenses or service delivery either through contractual agreements or resulting from the administration of a global budget. Entities are also considered at financial risk if they have provided funds that have a demonstrated risk of loss.

CCOs and the Medicaid-funded LTC system. In order to ensure shared responsibility for delivering high quality, person-centered care and to reduce costs, CCOs and the local LTC system will need to coordinate care and share accountability, including financial accountability. Supports and services for individuals with intellectual or developmental disabilities (I/DD) are also excluded from CCO budgets and Section C below describes how CCOs are expected to coordinate with that system. Section C also provides a description of the stakeholder-vetted approach to ensuring shared accountability.

Demonstration Proposal: This demonstration proposal builds upon the CCO model, bringing Medicare dollars into CCOs and allowing CCOs to better integrate and coordinate care for dually eligible individuals, with a combined benefit package and better aligned processes. The blended payments for Medicare and Medicaid services will allow CCOs to focus on the care that will best serve an individual, rather than which coverage should pay for it. This proposal requests a January 2014 start date for the demonstration, while CCOs are being launched in the fall of 2012; as such, some dually eligible individuals may be enrolled in CCOs for their Medicaid coverage. Participation in the demonstration will be voluntary for CCOs, but all CCOs will be required to be able to provide Medicare services to dually eligible enrollees by January 2014, either through participation in the demonstration, or through an owned, affiliated, or contracted Medicare plan, as some plans do now.

Population description

Oregon's proposal targets individuals who are dually eligible for Medicare and the full Medicaid benefit, with the exception of individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE).[7] This will include individuals eligible due to disability, blindness or age, who may or may not receive LTC supports and services, and who may currently receive Medicare- and Medicaid-covered services from one or more managed care organizations and/or on a fee-for-service basis. In January 2014, Oregon estimates there will be 68,000 individuals statewide who could participate in the proposed demonstration. This does not include individuals enrolled in Medicare who receive only a partial Medicaid benefit such as premium or cost-sharing assistance ("partially dually eligible").

Oregon has excelled in providing eligible individuals the ability to choose the most appropriate LTC setting and provider to meet their needs. A broad selection of LTC services and supports are available in Oregon, including a well-developed delivery system for home and community based services (HCBS), which many individuals strongly prefer. Receiving care in an HCBS setting helps to maintain an individual's independence and relationships, both of which can contribute to their overall health. The following table shows the LTC status and care setting for Oregon's dually eligible population and subcategories based on senior citizen status. Overall, 37% received LTC services. In Oregon, dually eligible individuals receiving LTC services were nearly twice as likely to do so in an HCBS setting as they are nationwide: more than 80% of the 21,550 dually eligible individuals in Oregon who received LTC services did so in an HCBS setting, whereas nationally the figure is only 44%.[8] Eighteen percent of individuals who receive LTC services in an institutional setting have a Severe and Persistent Mental Illness (SPMI) diagnosis, and 14% who receive LTC services in a HCBS setting have an SPMI diagnosis.[9]

[7] In 2010, there was an average monthly caseload of 816 dually eligible individuals enrolled in PACE. Individuals who leave the PACE program could participate voluntarily in the proposed demonstration, but this is not a desired outcome. This proposal requests further flexibilities for PACE via integrated care pilots; see end of Section C.

[8] Oregon Health Authority analysis of Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Long-Term Care Users: Spending Patterns across Institutional and Community-based Settings", October 2011, Table 7. This analysis excludes individuals with mixed institutional and community-based LTC.

[9] SPMI diagnosis based on ICD-9 codes from 2010 Medicaid claims and Medicare FFS claims; since no Medicare Advantage claims data was available, rates may be a slight underestimate. Specific ICD-9 codes used were:

Roughly half of the individuals who are dually eligible for Medicare and Medicaid in Oregon were younger than 65. These individuals typically become eligible for Medicare benefits due to disability after receiving Social Security Disability Income payments for at least 24 months. About 20% of dually eligible individuals have an SPMI diagnosis and 28% of individuals with an SPMI diagnosis receive LTC services. In addition, 12% or 7,000 dually eligible individuals have an intellectual or developmental disability.

Oregon Individuals Dually Eligible for Medicare and Medicaid, Average Monthly Caseload, 2010

	Total	Not Receiving LTC Services	Receiving LTC Services		
			In any LTC setting (total)	In an institutional setting	In an HCBS setting
Overall total	59,009 100% of total	37,459 63% of total	21,550 37% of total 100% of LTC recipients	4,054 19% of LTC recipients	17,496 81% of LTC recipients
Below age 65 (<65)	27,571 47% of total 100% of total <65	22,657 82% of total <65	4,914 18% of total <65 100% of LTC recipients <65	509 10% of LTC recipients <65	4,405 90% of LTC recipients <65
Age 65 and over (65+)	31,421 53% of total 100% of total 65+	14,785 47% of total 65+	16,636 53% of total 65+ 100% of LTC recipients 65+	3,545 21% of LTC recipients 65+	13,091 79% of LTC recipients 65+

Source: Analysis of the Oregon Health Authority's Division of Medical Assistance Programs "2486 Data" and Medicare A and B historical data performed by subcontracted researchers at Oregon Health Sciences University.

In addition to a mature HCBS delivery system, Oregon also enrolls a much higher proportion of individuals who are dually eligible in Medicaid managed care and Medicare Advantage plans rather than fee for services (FFS). In Oregon, 61% of dually eligible individuals are enrolled in Medicaid managed care plan for their physical health care while across the U.S. only 12% were enrolled in comprehensive managed care. Similarly, 47% of dually eligible individuals in Oregon are enrolled in a Medicare Advantage program—primarily Special Needs Plans (31%), which coordinate individuals' Medicare and Medicaid benefit to some extent. Nationally, only 15% of individuals who are dually eligible are enrolled in Medicare Advantage plans, including Special Needs Plans.[10]

Schizophrenia and other psychotic disorder (295.xx, 297.3, 298.8, 298.9), Major Depression and Bi-Polar Disorder (296.xx), Anxiety Disorders (300.3, 309.8), and Personality Disorders (301.22, 301.83). Individuals enrolled for fewer than three months during the calendar year were excluded as were individuals younger than 19.

[10] National statistics from statehealthfacts.org, "Total Dual Eligible Enrollment in Medicaid Managed Care, as of June 30, 2009" as cited by Verdier, James M. "Improving Care for Dual Eligibles: Opportunities for Medicare Managed Care Plans", World Congress Leadership Summit on Medicare, Falls Church, VA, July 15, 2011. Available at http://www.mathematica-mpr.com/publications/PDFs/health/dual_eligibles_verdier_071511.pdf (accessed March 1, 2012). Oregon statistics from Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report February 2011 and the Oregon Health Authority's Division of Medical Assistance Programs Decision Support/Surveillance and Utilization Review System (DSSURS) data warehouse, Jan 15, 2011 eligibility and January 2011 MMA return file (Analysis and Research run 2/9/2011).

C. Care Model Overview

Proposed delivery system model

Capacity for effective care integration and coordination is a key expectation for CCOs and will be an integral part of the CCO's delivery of benefits, particularly for dually eligible individuals who typically have more complex needs. Coordination will be patient- and family-centered, and is anticipated to be managed by recognized Patient-Centered Primary Care Homes (PCPCHs) increasingly over time. CCOs will also be expected to build relationships with members and their families (e.g. joint care planning and adherence to personal preferences to the greatest extent possible), by implementing systems for communication and collaboration between the primary care team and providers, sites and services within the CCO (e.g. service agreements between primary and specialty care providers), and by linkages to public health and other community services outside the CCO to ensure the health of the member.

Key elements of care coordination include:

- Member and family participation and engagement in care;
- Assessment of beneficiary strengths and risks, including screening, assessment and prioritization of services for high needs members;
- Development of individualized care plans in partnership with the member and their family;
- Comprehensive transitional care between care settings;
- Coordination of specialty and inpatient care by the primary care team or other lead care coordinator for those with intensive care needs;
- Coordination of behavioral and physical health care, including for individuals receiving Medicaid-funded LTC services;
- Complex care management or intensive care coordination, including team-based approaches for those assessed to have high needs;
- Individual and family support services;
- Health promotion;
- Use of non-traditional health workers such as Community Health Workers, Personal Health Navigators, and Peer Wellness Counselors to expand preventive care and health promotion beyond the clinical setting;
- Continuity of care; and
- Referral, information sharing and coordination with appropriate community, public health, local mental health authorities and social support services.

Oregon's PCPCH Standards and tiered recognition structure reflect these key elements and are one portion of the care coordination infrastructure CCOs will be putting in place. (See Appendix A for more information about PCPCH standards/structure.) For example, Old Town Clinic was recently recognized by Oregon as one of the first primary care homes. The clinic is located in the heart of downtown Portland and serves a low-income, often homeless population, providing integrated, team-based care to address their patients' individual needs. A team of professionals provide a range of services on site including primary and naturopathic care, treatment for injuries, minor procedures, acupuncture, and mental health and chemical dependency services. Old Town Clinic also offers activities to promote health and wellness such as occupational therapists, pain and chronic disease support groups, healthy cooking and yoga classes, and assistance connecting with social services.

Benefit design and accountability for providing services

In Oregon, physical health care, mental health and addictions services, and oral health care are currently provided by separate Medicaid managed care organizations. The CCO model integrates these services within a single organization, managing what is currently split among these different organizations with a stronger focus on primary and preventive care and evidence-based services in order to provide the right care in the right place at the right time.

The initial integration of Medicare and Medicaid benefits will be a combination of the two current benefit structures, with Medicare Parts A, B & D augmented with Medicaid coverage. The Medicaid portion of the combined benefit package will be based on the current coverage for dually eligible individuals in Oregon, which is a slightly reduced version of our Oregon Health Plan (OHP) Plus benefit package, including physical, behavioral and oral health services.[11] Currently, Medicaid pays members' premiums and all copays on OHP-covered services (items above the funding line on Oregon's Prioritized List of Health Services,[12] which serves as the basis of the OHP benefit package), and provides coverage of any OHP-covered services that are not covered under Medicare. For drug coverage, Medicare Part D will continue to be the primary drug coverage for dually eligible individuals under the demonstration. In addition, CCOs will be expected to provide health promotion and preventive services such as including smoking cessation programs, weight management programs, and lactation services.

Some individuals, when so assessed by their provider, may need specialized services or other types of supports that would be uniquely beneficial to their health, improve the quality of care, or ensure affordable delivery of services (beyond the standard services and supports, including the durable medical equipment already covered in the benefit package). Needs for these services and/or supports would be individually determined by the CCO in the best interests of the member and provision of the services would entail ongoing reporting and evaluation of the effectiveness of providing the benefit. CCOs would have the option to use their funds to cover such when appropriate. OHA is determining the rules and processes needed for these types of individualized benefits. These would be optional benefits provided to individuals or portions of the member population such as:

- Equipment or other supplies to maintain health and functionality, particularly related to chronic disease;
- Educational services, both group and individual;
- Culturally-specific or traditional health practices or services;
- Certain care by paraprofessionals/alternative care providers; and
- Home or site visits, particularly in coordination with mental health, community, and other public health services.

Behavioral health services

Mental health and chemical dependency treatment will be integrated with physical health care services into a person-centered care model established by the CCO. CCOs are expected to provide the full range of mental health services provided by the current Mental Health Organizations (MHOs), including inpatient, outpatient, case management, peer-delivered services, and psychiatric residential treatment

[11] Reduced OHP Plus package includes all services covered by OHP Plus (full), with the exception of having a limited dental package (no advanced restorative services) and acupuncture being limited to the treatment of chemical dependency (i.e. coverage for acupuncture for HIV is excluded). Oregon also has a separate, somewhat reduced package for its expansion population, called "OHP Standard."

[12] See Evidence-based Practices section below for more information on the Prioritized List.

services for children and adolescents. CCOs are also expected to provide supported employment services, and, by 2014, adult residential treatment for mental health and addictions.

CCOs and their delivery system network are expected to coordinate integrated mental health and chemical dependency treatment services[13] for members with related health services, as well as with services and supports provided by Medicaid-funded LTC providers and agencies as well as other health services not funded by the CCO when relevant. This expectation relates to members in all age groups and different levels of symptom and condition severity.

For members with serious mental health and chemical dependency conditions, the CCO delivery system network is expected to employ intensive care coordination or care management practices consistent with best practices or evidence-based treatment protocols. This includes members who may not be motivated to seek these services even when it would be in their best health interest to do so and members with limited cognitive capacity or limited social support systems.

CCOs are expected to coordinate care to ensure that individuals are receiving appropriate and coordinated care for both their physical and behavioral health needs. For individuals with mental illness, this includes ensuring that their physical health needs are not overlooked and that physical health side effects of any treatments are considered. For other individuals, this includes ensuring that behavioral health needs are identified proactively and addressed through early interventions. The goal is to provide behavioral health services as part of a holistic care team that addresses the person's whole needs. Best practices that CCOs may utilize to ensure these types of coordination include:

- Use of an embedded behaviorist or treatment provider in primary care settings;
- Use of a physical health care worker embedded in a community mental health center;
- Use of non-traditional health workers as part of the care team; and
- Virtual coordination approaches between physical and behavioral health providers.

Excluded and phased-in services

Certain services will be provided outside CCOs, either for the short term or permanently. Many services not covered by CCOs initially will be included by January 2014 when the demonstration starts. For example, non-emergent medical transportation will be provided outside of CCOs initially, but is expected to be included by 2013, prior to the start of the demonstration. Dental services will continue to be provided by separate Dental Care Organizations (DCOs) through July 2014, although individual CCOs and DCOs can come to an agreement to bring these services into the CCO sooner.

Certain mental health services currently provided outside of the Mental Health Organizations will be phased into CCOs over time; Adult residential treatment for mental health and addictions is expected to be included in CCOs in 2013, and thus will be included for the demonstration. In addition, Oregon State Hospital services will continue to be provided separately from CCOs, as individuals in the State Hospital are usually no longer Medicaid-eligible. OHA will continue to monitor patterns of admission and discharge from the State Hospital to ensure that CCOs are providing appropriate care to their enrollees and are not leading to overutilization of this setting. As part of the recent agreement with the U.S. Department of Justice, OHA will also be monitoring an extensive set of metrics to ensure that individuals

[13] Integrated mental health and chemical dependency services include: early intervention and prevention, screening and assessment, treatment engagement and follow-up, peer-delivered services, medication management as well as crisis intervention and diversionary services.

with Severe and Persistent Mental Illness (SPMI) are receiving care in the least restrictive, most integrated community setting possible.

Oregon's authorizing legislation, House Bill 3650 (2011) explicitly excludes Medicaid payment of mental health drugs (continuing the exclusion of these classes 7 and 11 drugs, in place since 2002) and Medicaid-funded LTC services (including nursing facility and HCBS) from being included in CCOs, and both will continue to be paid directly by the state. For dually eligible individuals, the exclusion of mental health drugs on the Medicaid side will not be as significant, since these drugs will largely be provided through Part D and thus will be included in CCOs participating in the demonstration (and will still be available to the member through Medicaid FFS if a drug is not covered by Part D). Medicaid waiver services to individuals with developmental disabilities and model waivers for children will also continue to be paid directly by the state. CCOs will be expected to effectively coordinate the care that they provide for their members with the entire continuum of services, ensuring that individuals are getting connected with needed services whether or not they are delivered through the CCO.

Medicaid-funded LTC and CCOs: coordination and shared accountability

Oregon is nationally recognized as a leader in provision of LTC services to individuals who are older adults and/or who have physical disabilities, including delivering a high proportion of services and supports in HCBS. Based on a national scorecard ranking from the SCAN foundation, Oregon's Medicaid-funded LTC system is ranked third in the nation.[14] Key highlights from this report include; high rankings for support of families and caregivers (Oregon's overall ranking: 3rd), for choice of setting and providers (5th), and for quality of life and quality of care (13th). According to a recent CMS report, Oregon's rates of potentially avoidable hospitalizations from the LTC system are among the lowest in the nation, with rates from nursing facility ranking 44th out of 49 states and rates from HCBS ranking 43rd out of 46 states.[15]

However, there is room for improvement in Oregon's LTC delivery system though better coordination with the health care delivery system. For example, the SCAN foundation report indicates that Oregon could improve its LTC system by reducing the number of new users of Medicaid-funded LTC services who first receive services in nursing homes instead of HCBS, and by reducing unnecessary hospitalizations from nursing homes. Better coordination should improve the integration of behavioral health services for members receiving Medicaid-funded LTC services, increasing access to screening and early identification of behavioral health issues. Improvements are also expected in medication management and reconciliation and in the coordination between CCOs and LTC facilities in the management of after-hours urgent needs.

OHA and DHS have worked extensively with stakeholders to develop strategies to maximize the strengths of Oregon's LTC system as well as leverage improved coordination through Health System Transformation and adoption of the CCO model.

To deliver high quality, person-centered care, and reduce costs, CCOs and the LTC system will need to coordinate care and share accountability. Because poor coordination between the two systems will

[14] Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." September 2011.

[15] Segal, Misha "Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations." September 2011, available at https://www.cms.gov/Insight-Briefs/downloads/PAHInsightBrief.pdf (accessed March 2, 2012)

result in increased costs for CCOs, including costs from avoidable hospitalizations and emergency room utilization, CCOs will have a substantial financial stake in improved coordination; they will also have the financial and information exchange resources needed to facilitate coordination. With the high proportion of individuals receiving LTC services who are also dually eligible for Medicare and Medicaid, this work to develop shared accountability is particularly important for coordinating the care for dually eligible individuals, making this an integral part of our demonstration proposal. The importance of coordinating between the two systems is not limited to the demonstration, however, and OHA and DHS will begin implementing the shared accountability approach as CCOs are formed, ensuring that these approaches are fully in place by the time the demonstration starts in 2014.

Promising Coordination Models: Promising models and pilot projects exist in Oregon for better coordinating care between the medical and LTC systems. Practices that are used in these projects are described below. These practices are not exclusive and can be combined.

- Co-Location or Team Approaches - These models include co-location of staff such as LTC case managers in medical settings (hospitals or primary care), care coordination positions jointly funded by the LTC and medical systems, or team approaches such as a multi-disciplinary care team including LTC representation.
- Services in Congregate Settings - Includes models where a range of LTC and medical services are provided in congregate settings, including Oregon's PACE program, such as licensed settings, apartment complexes, or day centers to a group of common beneficiaries. Services can be limited to one type of service such as 'in home' personal care services provided in an apartment complex or can be a comprehensive model such as the PACE program where all LTC and medical services are capitated and delivered by an eight-member interdisciplinary team with a merged social center and clinic setting. (See further information on proposed integrated care pilots at the end of this section.)
- Clinician/Home-Based Programs - These include increased use of Nurse Practitioners, Physician Assistants or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based, or nursing facility setting.

Shared Accountability: Although the models outlined above are promising, to achieve system-wide alignment, and ensure high quality, person-centered care, models such as these need to be brought to scale and supported by mechanisms to share accountability. Shared accountability approaches will support the policy goals for health system transformation and the policy goals for LTC placements, including individual choice and the right of the person to live as independently as possible, in the least restrictive setting. Oregon's shared accountability system is based on four components:

- Specific requirements for coordination between the two systems;
- Requirements to build or solidify relationships and coordination between CCOs and the local LTC field office through a memorandum of understanding (MOU) that describes clearly defined roles and responsibilities;
- Reporting and transparency of performance metrics related to better coordination between the two systems; and
- Incentives and/or penalties linked to performance metrics applied to the CCO and the LTC system (local LTC field offices and providers).

Specific coordination requirements: Oregon has created baseline expectations for CCOs and local field offices to improve coordination between CCOs and the Medicaid-funded LTC system. Examples of baseline expectations include: identification and prioritization of high needs members, development of

individualized person-centered care plans, coordination and communication to improve transitions of care, active engagement of individuals in their care, and use of team-based care approaches. See Appendix G for more information about these baseline expectations. Expectations are included in CCO criteria, and could also be implemented through the OHA/DHS rules; contracts including the CCO contracts, LTC provider contracts, and the DHS LTC Inter-governmental Agreements (IGA) with AAAs.

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 Aging and People with Disabilities (APD) local office to develop a Memorandum of Understanding (MOU) or contract, detailing how they will coordinate and the roles and responsibilities of each party. This MOU or contract will be the mechanism for the two systems to create agreements and working relationships in order to implement the requirements for coordination in a way that works for both systems locally. A template and guidance on creating these MOUs was posted in April 2012; see Appendix H for more information. Local AAAs may create contracts with the CCO to supplement or enhance the activities described in the MOU.

Metrics: Oregon is working to develop metrics related to shared accountability applicable to CCOs, the LTC system, and both. A balanced set of metrics will be chosen, 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 as CCOs become operational, starting in 2013, with a general approach of:

- First CCO year: reporting process measures and feasible outcomes measures, while the full set of outcome measures are being developed. See Appendix D for a full list of planned CCO measures. Some examples of planned measures include:
    - Potentially avoidable emergency department visits;
    - Follow-up after hospitalization for mental illness;
    - Hospital readmission rates, including readmissions to psychiatric care;
    - Experience of care from member experience survey; and
    - Planning for end-of-life care.
- Second CCO year or later: measurement and reporting of additional outcome measures as they are developed.
- Measurement development and changes to measures for shared accountability for LTC will be defined through the same process used for overall CCO metric development.

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. The development of final financial alignment requirements is also dependent on CMS requirements related to Oregon's participation in the CMS Financial Alignment Demonstration. There are several options for holding CCOs financially accountable:

- Relating a portion of overall CCO quality incentive payments to metrics for shared accountability with LTC.
- For LTC providers and local LTC offices, financial incentives tied to performance metrics, depending on availability of funding.
- Shared savings arrangements between CCOs and LTC partners around benchmarks such as reduced rehospitalization rates and emergency department utilization (and/or other health system costs).
- Exploring with CMS the use of other mechanisms, including tying a portion of demonstration CCO quality payments to shared accountability for LTC.

As with performance measurement, financial accountability will be phased in, potentially with an initial focus on accountability for reporting on performance while work is underway to develop outcome and utilization/cost metrics and to find the best way to tie incentives to them. Another approach that will be explored is providing quality performance data on LTC providers. See Appendix G for additional information about Oregon's shared accountability strategic framework.

Coordination with Developmental Disabilities Services

The Department of Human Services, Office of Developmental Disabilities, supports individuals with intellectual or other developmental disabilities (I/DD) throughout their life span. All individuals who request supports are provided with case management through the county systems. Adults (18 and older) who live at home or in their own home and qualify for Medicaid can be provided case management and in home and community supports through Adult Support Service Brokerages. Oregon's model of support is based on the values that individuals with developmental disabilities need to be fully engaged in their communities. To that end, Oregon does not operate any institution, private or public, for people with I/DD; all services are provided in the community. For those individuals who cannot continue to live with families or live on their own with some supports, there is a network of group homes and foster care. But the majority of people, even people with some of the most significant disabilities, live at home.

Oregon's system serves approximately 17,000 Medicaid-eligible individuals with I/DD, approximately 45% of whom are dually eligible. The population of individuals with I/DD has a significant burden of both common chronic diseases, as well as health conditions related to their individual disability. Research has shown an increased incidence of diseases (those requiring both behavioral health treatment and traditional medical treatment), in addition to the fact that this population has a lower rate of receiving routine health screening and prevention services. While individuals with I/DD will continue to receive their I/DD services in the way that they do now, those that are enrolled in CCOs will receive their physical and behavioral health services through the CCO. Dually eligible individuals with I/DD will be able to participate in the demonstration to integrate and align their Medicaid and Medicare physical, behavioral, and oral health services through a CCO.

CCOs will be expected to establish and maintain relationships with the developmental disabilities service system in their area, and to work with that system to effectively coordinate services and supports to meet the complex needs of this population. To support these efforts at coordination, DHS has developed county fact sheets providing information on the I/DD population in the area, contact information for the county program manager and for the Adult Support Service Brokerage in the county, and the names of residential providers in the area. DHS is exploring how to support CCO coordination with I/DD services for their members with I/DD, including potentially sharing additional client-specific data related to the CCO's members with I/DD. OHA will reflect the disabled population, including the I/DD population in the quality metrics for CCOs, and in the metrics specific to this demonstration, to track and monitor outcomes and ensure that CCOs are addressing the needs of this population, and work to reduce disparities.

Evidence-based practices

Evidence-based benefit design in Oregon has been a centerpiece of the Oregon Health Plan since the original 1115 Medicaid Waiver instituted the Prioritized List of Health Services that is the basis of the benefits covered by the current Medicaid managed care and FFS programs. Oregon's Health Services Commission, a Governor-appointed, Senate-confirmed group of volunteer experts and public members,

regularly reviews the best available evidence on clinical effectiveness and cost-effectiveness to rank order health services according to their relative importance to the entire population covered. The updated List is submitted biennially to the Legislature, which "draws a line" on the list to set the Medicaid services funding level as part of allocating available resources in the state's budget process. About 70 percent of over 600 lines of condition-treatment pairs are covered, with some additional coverage resulting from exceptions due to impact on co-morbid conditions. Diagnostic services needed to determine the patient's condition are covered, as are ancillary services medically appropriate for the treatment of covered conditions, including hospital services and prescription drugs.

Effective January 2012, this work has transitioned to the Health Evidence Review Commission (HERC), along with comparative effectiveness reviews of medical technology previously managed by another body. The Governor's charge to the HERC is to expand upon its work to date by developing, and gaining consensus on, evidence-based clinical guidelines and other coverage guidance that can help newly forming CCOs provide high quality care, reduce spending on ineffective services, and enhance individual safety. One such guideline—on treatment options for low back pain—has already been produced, along with consumer and provider educational materials. Regarding drugs, Oregon's Preferred Drug List is being developed by the state's public Pharmacy and Therapeutics Committee that analyzes evidence to establish which drugs are the most effective with regular updates as new information becomes available. Dually eligible beneficiaries will benefit from this evidence-based work as CCOs ensure the right care is being provided appropriately across both benefit packages.

At the plan level, CCOs will be expected to establish an approach to assuring best clinical practices, which may include use of a clinical advisory panel. Each CCO's approach will be subject to OHA approval. If a clinical advisory panel is convened by a CCO, OHPB guidance suggests that the panel should have representation on the governing board. If not, the governing board must still include two clinical providers in active practice (a primary care physician or nurse practitioner and a mental health or chemical dependency treatment provider) who can provide guidance on best practices.

CCOs will be expected to work with their provider network, including PCPCHs, to ensure that approaches to care coordination and management are based on evidence-based practices. Key areas where CCOs and their providers will be expected to utilize evidence-based approaches include comprehensive community needs assessments and interventions including developmental screening, team-based care approaches, chronic condition management, integrated behavioral health screening and treatment, and transitional care practices. Nationally, transitional care has been widely acknowledged as a critical component of quality health care delivery systems and acknowledged by Oregon legislators and stakeholders as a key element to meeting the Triple Aim. As such CCOs and their partners are expected to improve evidence-based approaches to transition. For instance, several AAAs have piloted or are developing transitional care models based on the Eric Coleman Model.

The PCPCH model itself is based on local and national best practice approaches. The model incorporates lessons learned from a local primary care transformation initiative through CareOregon, Oregon's largest Medicaid managed care plan, as well as recommendations from the US Preventive Services Task Force, the Bright Futures Guidelines and the National Committee on Quality Assurance (NCQA). The model also incorporates use of standardized patient experience of care surveys and tracking quality indicators endorsed by the National Quality Forum and aligned with Meaningful Use standards at a practice level. As the evidence-base for the primary care home model continues to grow, Oregon's PCPCH model will be refined to incorporate new best practices and proven approaches to improving care delivery.

Finally, CCOs will receive information about and support for implementing evidence-based and emerging best practices via a learning institute and collaborative established by the state in partnership with the Oregon's Northwest Health Foundation. The collaborative, developed through a public stakeholder process, is being initiated now to provide technical assistance and quality improvement resources to practices working to become recognized as PCPCHs and will be expanded to provide tools to assist CCOs in transforming their delivery systems to a new model of care.

Other elements of delivery system

Available networks of providers: Oregon's high managed care penetration rates in both Medicaid and Medicare indicate that much of Oregon's delivery system is already prepared to meet traditional Medicaid and Medicare managed care network adequacy standards including timely care, access to an appropriate range of service providers and settings, and provider choice.

However, as described above, CCOs are being asked to redesign care delivery in a way that promotes the Triple Aim and provision of the right care, at the right time, in the right setting. This will require that networks be reconfigured somewhat to address the needs of the communities served by each CCO. Oregon is supporting capacity in key areas identified by OHA and stakeholders, including care coordination across systems, use of PCPCHs, and non-traditional health workers.

- *Care Coordination*: Beyond having a sufficient number of providers and facilities to deliver the range of covered services, CCOs must also ensure coordination across the network (and outside of it) to achieve adequate capacity in alignment with the vision of HB 3650. Meeting expectations for care coordination will require a combination of appropriately trained personnel, institutional partnerships, and operating policies, procedures, and/or provider agreements that clearly outline expectations for communication and care planning. CCOs will be asked to develop formal relationships with external providers, including the Medicaid-funded LTC system, community health partners, and state and local government support services in their service areas and to describe coordination agreements among those groups.
- *Patient-Centered Primary Care Homes*: The state's recognition process for PCPCHs ensures that practices meet the core standards of access, accountability, comprehensive care, continuity of care, coordination and integration, and patient- and family-centeredness. As noted previously, since the PCPCH program launched in October 2011, more than 150 clinics have applied, and 130 have already been recognized as PCPCHs.
- *Non-traditional Health Workers*: A subcommittee of the Oregon Health Policy Board (OHPB) recently developed professional competencies and training recommendations for community health workers, peer wellness specialists, and patient navigators. In their applications for certification, CCOs will be asked how they plan to use these workers to help members access needed services and participate as equal partners in their own care. A convenience survey undertaken by the OHPB subcommittee in the course of its work received almost 600 responses from self-identified non-traditional health workers currently working in Oregon, providing services such as information and referral, counseling and support, client advocacy, and system navigation. In addition, OHA and DHS are exploring how to potentially leverage current LTC homecare providers as part of the care team.

CCOs will take a proactive approach to network development via a required community needs assessment, which each CCO will conduct at its inception and update annually. Conducted with guidance from OHA, the needs assessment will provide information on community health needs, health disparities, resources and barriers to care, and typical patterns of health care utilization. CCOs will use

this information to assess whether their provider networks and points of access are sufficient to meet the needs of their local communities. Where capacity is under or over developed, CCOs will make plans to strengthen or adjust network capacity as needed beyond the stated minimum standards. The needs assessment will include a focus on health and health care disparities in the community and CCOs will be expected to develop plans, which may include workforce development or redesign, for addressing and eliminating disparities over time.

Service area and enrollment: Oregon seeks to implement the demonstration on a statewide basis. Based on the application and certification process currently underway, CCOs are expected to be operational statewide prior to the beginning of the demonstration in January 2014. Since participation in the demonstration will be voluntary for CCOs, whether or not the demonstration will occur on a statewide basis will depend on interest from CCOs, but statewide or near statewide participation is probable assuming the demonstration terms are acceptable to CCOs.

OHA proposes to enroll beneficiaries in the demonstration using passive enrollment[16] with an option to opt-out, following the CMS-required beneficiary notification process and timelines. In order to encourage beneficiaries to enroll in coordinated care while maintaining continuity of care, individuals who are currently enrolled in fee-for-service (FFS) Medicare will be passively enrolled, as will individuals enrolled in a Medicare Advantage plan that does not manage care (private FFS or cost plans). Individuals enrolled in a Medicare Advantage plan other than private FFS or cost plans will not be passively enrolled in the demonstration but will be notified about the demonstration plan(s) available to them and encouraged to consider enrolling. Individuals who are enrolled in a Medicare Advantage plan affiliated with a CCO that participates in the demonstration will be transitioned into the demonstration plan but will also be permitted to opt out. New dually eligible individuals who are not already enrolled in a Medicare Advantage plan (other than private FFS or cost plans) will be enrolled in the demonstration with the ability to opt-out.

Beneficiary notifications will include information about opting out and which plan beneficiaries will be enrolled in if they do not opt out, and choice counseling will be available to individuals as it is now, to assist them in making this decision. We received a number of specific comments with suggestions for how to ensure adequate beneficiary notification and education related to passive enrollment, which will help to inform the work to develop these processes.

Passive enrollment will follow the Medicare-required timeline for both the Medicaid and Medicare benefits, and individuals will be permitted to opt out of the demonstration and remain in the CCO for Medicaid, or to opt out of the CCO entirely. Individuals will be given a chance to opt out prior to the passive enrollment, and will also be able to disenroll from the demonstration (and the CCO for Medicaid, if desired) at any time; individuals will continue to have the right to change their Medicare plan throughout the plan year. Individuals that wish to be enrolled in a CCO for Medicare and Medicaid benefits through the demonstration will be required to get their Part D benefits through the CCO; any choice of a separate Part D plan will remove the individual from the demonstration.

[16] In this proposal, OHA uses the term "passive enrollment" to refer to the enrollment of individuals into the demonstration where they are notified in advance that they will be enrolled in the demonstration if they do not opt out, as described in the text. This term is used, rather than other terms such as "auto-enrollment" or "facilitated enrollment," because it is the term that CMS has used in the context of this demonstration.

Context of other CMS initiatives and Health System Transformation

Current Medicaid waivers and/or state plan services available to this population:
CCOs in Oregon will provide physical, behavioral, and oral health services covered under the state plan and 1115 waiver. Concurrent with this proposal, Oregon has submitted an 1115 waiver amendment related to the overall implementation of the CCO model. As described above, 1915 (c) LTC services for people who are aged and physically disabled are excluded from the CCO global budgets, as are services under Oregon's two other home and community based 1915(c) waivers for support services for people with developmental disabilities and three model waivers for children; CCOs are still responsible for the health care needs for individuals receiving these excluded 1915(c) and waiver services.

Existing managed LTC programs: Oregon does not currently have any managed LTC programs, other than PACE.

Existing specialty behavioral health plans: Currently, OHA contracts with ten specialty behavioral healthcare organizations known as Mental Health Organizations (MHOs). There are different types of MHOs including county governmental, not-for-profit, regional governmental and for-profit organized entities that operate or contract with community mental health services and private mental health provider organizations. MHOs have historically received capitation payments and have managed much of the risk of providing mental health treatment to individuals of all ages eligible for the Oregon Health Plan; 96 percent of dually eligible individuals in Oregon not enrolled in a PACE plan are enrolled in an MHO. Under Health System Transformation, management of risk for providing mental health services will be transferred to CCOs. Based on the Letters of Intent received, existing MHOs will either become part of new CCOs or become subcontractors of CCOs. As described above in the Behavioral Health Services section, CCOs are expected to provide a full range of mental health services.

Integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs: Managed care plans in Oregon have significant experience serving the dually eligible population for both their Medicare and Medicaid benefits, allowing the plans to coordinate benefits and care across the two separate plans. Thirty-one percent of dually eligible individuals in Oregon are enrolled in a Medicare Special Needs Plan (SNP), most of whom are also enrolled in the corresponding Medicaid Managed Care Organization (MCO); 17 percent of dually eligible individuals are enrolled in a non-SNP Medicare Advantage plan, many of whom are also enrolled in an affiliated Medicaid MCO plan. Oregon's demonstration proposal builds on this plan experience in serving this population and coordinating across the two benefit packages by allowing these plans to participate in the demonstration and more effectively integrate the benefits, plan materials, and administrative processes to create a seamless experience for beneficiaries.

Oregon has supported an urban PACE program, Providence Elderplace, since 1987 with steady growth in the number of participants and an excellent record of cost containment and better health outcomes for participants. This PACE program will continue under the demonstration and PACE participants will not be passively enrolled in CCOs. In addition, Oregon is requesting a waiver of certain PACE requirements to allow the expansion of this integrated care model as part of this demonstration (see integrated care pilots description at the end of Section C).

Other State payment/delivery efforts underway: The demonstration to integrate and coordinate care for dually eligible individuals is part of Oregon's larger Health System Transformation efforts, including the creation of CCOs, and the use of PCPCHs, as described throughout this proposal.

Other CMS payment/delivery initiatives or demonstrations: As described in this proposal, Oregon's health home initiative (the PCPCH model) is integral to the overall CCO model. CMS approved a state plan amendment to provide enhanced reimbursement to PCPCHs for serving qualified OHP members under the Medicaid Health Home option (Affordable Care Act Section 2703). Similarly, the PCPCH model is largely consistent with the aims of the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration including but not limited to: the use of alternative payment methodologies, enhancing access, improved care coordination and team-based care approaches as well as beneficiary involvement in care and the promotion of evidence-based or best practices approaches. Oregon does not have any MAPCP sites.

Aside from the fact that they are risk-bearing entities, CCOs in Oregon share several key features with the national Accountable Care Organization model including: comprehensive care management and person-centered care; meaningful participation by local communities in the governance structure; promotion of early intervention and prevention; emphasis on accountability for outcomes; and development and use of a learning collaborative approach to promote best practices. Oregon's CCO model is also aligned with the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Home Residents through the use of an evidence-based approach to comprehensive transitional care.

Integrated care pilots: PACE innovations and Congregate Housing with Services

As part of this demonstration, Oregon would like to pursue flexibility and innovation in the areas of PACE and Congregate Housing with Services. These pilot projects are intended to complement and align with CCO and PCPCH efforts. These projects will provide extraordinary opportunities to encourage and test innovative models for robust care coordination and integrated, local, comprehensive care and services, including health and social supports/LTC services. Demonstrating the effectiveness of these models will support Oregon's long-range goals of having fully integrated care options available.

Program of All-Inclusive Care for the Elderly (PACE):
Oregon is proposing an expedited process for approval of either waiver or flexible interpretation of the federal Program of All Inclusive Care for the Elderly (PACE) regulations (42 CFR 460). The goal of this request is 1) to test and evaluate the impact of the proposed new practices and 2) demonstrate to new CCOs and stakeholders the value of a fully integrated care model for dually eligible individuals receiving LTC services while honoring the intent of the exclusion of LTC from CCOs in HB 3650.

The proposed demonstration activities are designed to:

- Reduce existing regulatory and financial barriers that have prevented expansion of a PACE option throughout the state;
- Align PACE regulatory, consumer protections and quality measures with CCOs; and
- Provide increased ability for Oregon to maximize opportunities for financial alignments, create savings and promote better health outcomes for some of Oregon's highest need, highest cost dually eligible individuals.

With approved flexibilities, Oregon envisions creating a "mobile PACE" program to encourage expansion and greater access to this program. Specific flexibilities requested will be provided to CMS during the memorandum of understanding development process between CMS and Oregon.

Congregate Housing with Services: Oregon is proposing a program to test a Congregate Housing with Services model at up to three pilot sites (for no more than 1,000 total individuals). The Oregon

Congregate Housing with Services pilots will include the use of a multi-agency consortium of experienced providers to deliver social, support, and health services. This consortium will develop the specific comprehensive services package to be delivered at subsidized housing apartments or other highly concentrated, naturally occurring communities of dually eligible individuals, such as low-income neighborhoods, in which a significant proportion of residents are dually eligible. The program design will be responsive to an initial comprehensive community service needs assessment and will include service agreements to leverage the resources of all partners. Service packages could include: service coordination, home and personal care, resident inclusion and involvement, recreation/community inclusion, money management, emergency fund, technology innovation and support, transportation. Pilot sites would be required to partner and coordinate with CCOs for behavioral supports, substance abuse treatment, acute and primary care, and CCO models such as onsite nurse practitioners and wellness programs. Enrollees will continue to have their choice of provider, regardless of their residence.

As part of Health System Transformation, Oregon plans to test and evaluate this model of pairing housing with services for its potential to improve health outcomes and lower costs for CCO members who are dually eligible, highlighting approaches and resources that:

- target social determinants of health;
- address health disparities including those related to race/ethnicity/language; and
- include prevention and wellness programs.

By targeting a low-income population with a highly coordinated and efficient model of support, Oregon hopes to achieve significant outcome improvements such as: delay of entry into LTC, creation of a culture of wellness, and lower LTC/health costs, and achieve better health outcomes within often disenfranchised populations. For example, one potential pilot site has a sub-population of Chinese-speaking and Russian-speaking tenants, groups that have often found barriers to accessing care and have experienced health disparities.

D. Stakeholder Engagement and Beneficiary Protections

Stakeholder engagement leading up to proposal

Consistent with Oregon's reputation as a leader in including stakeholder input into health policy development, Oregon has committed itself to obtaining beneficiary and other stakeholder feedback throughout the process of planning for Health System Transformation, CCO implementation, and this demonstration proposal in particular. These efforts have included: (1) OHPB meetings, workgroups, and public comment; (2) the OHPB's Medicare-Medicaid Integration of Care and Services Work Group; (3) OHA's Health System Transformation Community Meetings; (4) Medicare and Medicaid Integration Sub Group/HB 5030 Budget Note; (5) CMS beneficiary focus groups; (6) OHA's Dual Eligible Beneficiary Listening Groups; (7) PCPCH development stakeholder groups; and (8) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 60 public meetings in total leading up to the development of the overall CCO implementation proposal and this demonstration proposal. Appendix E includes a summary of this outreach, and Appendix A includes links to the final products related to these efforts.

Stakeholder feedback on the draft proposal

The draft demonstration proposal was posted for public comment from March 5 through April 13, 2012. Twenty public comments were received during that comment period, from a variety of stakeholder perspectives; the public comments received are posted online, and the link is available in Appendix A.

Stakeholders were also engaged during this time meeting in several public meetings and stakeholder groups. A joint OHA/DHS webinar on March 20 for stakeholders and LTC local offices focused on Oregon's Health System Transformation broadly and the demonstration proposal in particular, and included a question and answer session. The Medicare/Medicaid Alignment project director presented to the Medicaid Advisory Committee on March 28 about the demonstration proposal. Stakeholders also had an opportunity to ask questions and provide feedback on the proposal via forums related to the general CCO implementation, including a public webinar on March 2 and several webinars for RFA applicants. In addition to these public meetings, stakeholder feedback was provided through a variety of working groups, including several meetings with a subgroup of the state's Developmental Disabilities Coalition, a meeting with a variety of stakeholders around how best to align the Medicare and Medicaid appeals processes, and a meeting with current Medicare/Medicaid plans.

Oregon consulted its nine tribes around the larger CCO proposal as part of the 1115 waiver process, and project staff shared the draft demonstration proposal and met with key tribal representatives to get their comments and input. Oregon will partner with tribes and CMS to think through ways to better serve tribal members who are dually eligible, either through CCOs participating in the demonstration or through other mechanisms.

Feedback from stakeholders both through formal public comments and through the variety of public meetings, workgroups, and informal comments, has been extremely valuable in refining the draft proposal and will help to inform the work to further develop and implement the demonstration moving forward. Changes to this proposal in response to feedback include: the request for a 2014 start date, and the decision that the demonstration will be voluntary for CCOs; greater focus on coordination between CCOs and the local Developmental Disabilities system; removing the request to require CCOs to use a statewide Preferred Drug List; more detail on plans for passive enrollment; and a variety of clarifications of points of confusion or concern.

Ongoing stakeholder engagement

As has already been demonstrated, Oregon is committed to collecting, considering and incorporating stakeholder feedback, and will continue to be going forward. The OHPB will oversee the implementation of Health System Transformation, including Oregon's demonstration for integrating Medicare and Medicaid (proposed in this document), and will be an ongoing forum for public input. OHA realizes that the transition to the CCO model of care and implementation of the demonstration proposal will require input from and education of all affected stakeholders. In particular, OHA plans to engage stakeholders through existing and ad hoc workgroups or meetings while negotiating the terms of the demonstration with CMS, including CCOs, local LTC AAA/APD offices, I/DD stakeholders and advocates, and LTC stakeholders and advocates. OHA will partner with DHS to engage stakeholders to further develop shared accountability for LTC metrics and financial accountability mechanisms. OHA plans to facilitate strong stakeholder and community involvement through transparent performance reporting and holding CCOs accountable to their community governing boards and members.

In terms of enrollment transitions, OHA will work with CMS to design appropriate communication, outreach and notification materials, to describe the options available to dually eligible individuals in

areas where CCOs are participating in the demonstration. See Section C, Service area and enrollment, for more details on communications related to enrollment in the demonstration.

In terms of accessibility to information, OHA's Publications and Design Section translates materials to other languages and to alternative formats when requested. During the CCO development process, OHA proactively made many materials available in Spanish. During stakeholder meetings, OHA produced alternate versions of materials upon request, including Braille, audio, and large format.

Beneficiary protections

OHA will work with CMS to ensure that strong beneficiary protections are in place to ensure individuals' health and safety and that individuals have access to high quality health and supportive services necessary to meet their needs.

Continuity of care protections will be maintained under CCOs, including requiring that the CCO ensure each member has an ongoing source of primary care appropriate to their needs, and requiring that the member be allowed to choose their provider from within the CCO's provider panel. CCOs will be required to have adequate provider capacity to serve their members' needs, and the standard for determining network adequacy will go beyond the traditional standard of member/patient access to a range of providers – physical health, behavioral health, and oral health care – to require that members receive access to person-centered care via a primary care team, preferably in a PCPCH setting. CCOs will be required to ensure that they have an adequate provider panel to address special needs populations, and to establish a process for referrals to non-panel providers when provider panels are unable to meet specific individual needs. OHA is exploring how best to ensure smooth transitions for current authorizations and referral patterns when individuals transition into new CCOs, and specific feedback received through the public comments will help to inform this work.

Since the demonstration will involve expanding CCO enrollment for dual eligible individuals through passive enrollment with opt-out, individuals who are currently in fee-for-service Medicare and/or Medicaid are expected to be enrolled in CCOs. In order to ensure a safe transition for these individuals from FFS to CCOs, to the greatest extent possible, OHA will work with CCOs to ensure that necessary information is shared about the needs of particular groups of members (such as those with prior authorizations for medications, equipment, treatments, surgeries; in-home services; residential placements). In addition, for individuals whose care needs are particularly sensitive (constant oxygen, specialized treatment plans), OHA will work to ensure that there are appropriate handoffs of care. OHA plans to monitor these cases to ensure quality of care and positive outcomes.

OHA will work with CMS to develop integrated grievance and appeals processes, to meet the Medicaid and Medicare requirements through a combined process that will be easier for beneficiaries to navigate and will ensure that important beneficiary protections are maintained and strengthened. OHA will ensure the privacy of enrollee health records and provide for access by enrollees to such records.

E. Financing and Payment

Financial alignment model

As part of the overall Health System Transformation effort that includes providing global budgets to CCOs, OHA proposes to provide blended Medicare and Medicaid payments to CCOs under the capitated financial alignment model outlined by CMS in the July 8, 2011 State Medicaid Director Letter. However,

as outlined below in Section H, OHA has concerns about whether the standard CMS approach and terms for this demonstration will be workable for Oregon's unique, mature managed care delivery system. OHA anticipates further discussing savings opportunities and potential targets under the demonstration with CMS as part of the negotiation process for this initiative.

Payments to plans

The proposed demonstration leverages OHA's effort to integrate payments to CCOs for Medicaid-covered physical, behavioral and oral health services. Integrated payments provide CCOs with the flexibility to invest available funds in cost effective forms of care. OHA intends to provide each CCO with a global budget that combines funding streams in a manner that allows this flexibility and creates a single point of accountability for members' health and their access to and experience of care. In addition, OHA is currently considering potential reinsurance or risk-sharing arrangements with CCOs that enable implementation of innovative care models while reducing risk to CCOs.

The proposed demonstration envisions CCOs entering into three-way contracts to receive blended capitated rates for Medicare and Medicaid services currently provided to individuals who are dually eligible under separate capitated rates. The blended rate will be developed by CMS and OHA actuaries and will include a risk-adjustment method that ensures that incentives do not work against CCOs serving individuals with relatively poor health. The blended rate will reflect the fundamental care coordination and management activities CCOs are expected to perform. Finally, as described in the benefits section, LTC and certain other services will continue to be purchased outside of CCOs in accordance with state legislation. See Appendix F for an overview of services in the capitated portion of global budget payments. As mentioned above, OHA has some concerns about the ability to create a blended rate that works for Oregon. See Section H below for further discussion.

After the first year of CCO operation, a financial incentive structure will be incorporated in the overall global budget methodology to reward CCOs for improving health outcomes and managing costs. Incentives will be designed in conjunction with the CCO accountability (quality and outcomes) metrics described below in Section F. There will also be quality payments for CCOs participating in the demonstration beginning in the first year of the demonstration, including a payment withhold that plans could earn back based on meeting quality standards and performance targets for care for dually eligible individuals. As part of one or both of these types of payments, CCOs will be held accountable for metrics related to shared accountability with the LTC system, as described in Section C above.

Payments to providers

Payment arrangements and potential financial incentives for providers and contractors are to be determined by individual CCOs, but CCOs will be encouraged to align financial and other incentives across provider types and settings of care by using alternative payment methodologies (bundled payments, administrative per member per month payment, quality bonuses, gain-sharing arrangements, etc.). CCOs will move from a traditionally FFS payment system to alternative methods that align incentives to providers and patients to support desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. In their applications for certification, CCOS are expected to describe how they will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for their members.

F. Expected Outcomes

Monitoring of key quality and cost outcomes and development of performance targets

Oregon's authorizing legislation, HB 3650, directed that CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures. These strategies function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in accordance with Oregon's goals. In consultations with stakeholders, the state has developed an initial list of access, member experience, quality, and health or outcome measures for which CCOs will be responsible. This initial list includes measures focused on or reported separately for individuals receiving LTC services to ensure CCOs coordinate with and share accountability with LTC systems. Individuals with disabilities, including intellectual and developmental disabilities, will also be reflected in the metrics, to ensure that CCOs are addressing the needs of this population and working to reduce health disparities. In addition, Oregon will work with CMS to identify further performance measures relevant to dually eligible individuals, and may add additional measures related to shared accountability with the LTC system, as described above in Section C. The authorizing legislation for CCOs creates a Metrics and Scoring Committee that will help further define initial performance measures and will review and maintain the list of measures over time. See Appendix D for initial accountability metrics for CCOs.

Performance expectations related to these metrics will be phased in to allow CCOs time to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards. In the first year of CCO operations, CCOs will be accountable for reporting data, including for measures related to shared accountability for LTC. In the second year of CCO operation, when the demonstration will begin, CCOs will be accountable for meeting minimum standards or for improving on their past year performance, depending on the specific measure. As described above in Section E, Oregon plans to offer incentives to reinforce these performance expectations, with the specific incentive design to be determined.

Depending on the metric, data may flow from CCOs to OHA or the reverse. OHA has a strong history of performance measurement and reporting through the Medicaid program and will build on its capacity to minimize CCO reporting burden while providing all parties with the data needed to monitor and evaluate CCOs. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs.

Potential improvement targets for the metrics have not yet been set. The Metrics and Scoring Committee referenced above will use data from the first year of CCO operation, as well as state and national benchmarks, to set minimum performance standards and/or improvement targets on all CCO accountability metrics.

Expected impact of the demonstration on Medicare/Medicaid costs

Many opportunities exist to improve both the quality and individual experience of care and contain costs, through further integration, coordination, and delivery of person-centered care. Oregon expects CCOs to be able to:

- coordinate and integrate care, including intensive case management for high needs members, and better integration of physical and behavioral health care;
- focus on prevention to keep individuals healthier longer;
- address needs in lower levels of care before problems become acute;
- improve care planning and transitions;
- invest in cost effective interventions and infrastructure;
- reduce unwarranted or duplicative care; and
- reduce medical errors.

Some of these opportunities to improve care and reduce costs will start to be realized in the short-term. For example:

- administrative alignment and the integration of managed care plans for physical and behavioral health as well as aligning Medicare and Medicaid administrative processes will reduce administrative costs;
- better prevention and case management will begin to reduce hospitalization and emergency room use;
- increased financial flexibility will enable cost effective care; and
- integration of Medicaid and Medicare benefits will help improve medication management, adherence and reconciliation.

Initial savings may need to be invested in further developing the models and building the infrastructure to support them, but over time, savings from these areas will grow and other areas will also start to yield results, for example, as improved management of chronic conditions slows individuals' decline in health status, expenditures on expensive specialty care will also be reduced. In addition, an improved understanding of and system capacity to serve the needs of individuals with behavioral health needs will also help to avoid costly emergency care. Also, improved engagement of individuals in managing their own health conditions will be a key component of creating a system which keeps individuals healthy and ultimately bends the cost curve. In all cases, the expected benefits from more integrated and coordinated care should increase over time as CCOs gain momentum and experience implementing the care model.

OHA and CMS have initiated an analysis of the cost saving potential of the proposed demonstration in terms of its anticipated magnitude, timeline and effect on Medicaid and Medicare expenditures. Preliminary analyses are underway, and additional input from potential CCOs and contracted consultants, as well as access to Medicare Part D data, will greatly contribute to further developing expectations of the impact of the proposed demonstration on costs.

G. Infrastructure and Implementation

State infrastructure/capacity to implement and oversee the demonstration

OHA and DHS share responsibility for administering the state's Medicaid program. In general terms, OHA has responsibility for Medicaid and other health coverage programs as well as public health, and DHS has responsibility for social services and LTC. Oregon has extensive experience managing the Section 1115 Waiver Demonstration Medicaid managed care system first implemented (for both Medicaid-only and dually eligible beneficiaries) in 1993/4. Oregon will build on this infrastructure and

capacity in implementing the CCO model and the proposed demonstration integrating coverage for dually eligible beneficiaries with a blended Medicare and Medicaid capitation rate.

- Oregon's Medicaid staff are largely in-house, within the OHA's Division of Medical Assistance Programs (DMAP), including fiscal agent responsibilities, program call centers for beneficiaries and providers, audit and program integrity, grievances and appeals, claims processing, provider enrollment, etc.
- DMAP staff work closely with Oregon's Chartered Value Exchange and with Oregon's Office of Health Policy and Research to ensure that there are robust metrics and systems of accountability for OHA contracting health plans to complement parallel efforts for PEBB/OEBB health plans and other commercial insurers, as well as Medicare Advantage plans.
- Oregon is also experienced in actuarial matters relating to Medicaid and dually eligible beneficiaries, and has developed an in-house Actuarial Services Unit, which will work with actuarial consultants and CMS to develop appropriate blended capitation rates for the demonstration.
- Oregon's Department of Consumer and Business Services, Insurance Division, will explore the feasibility of developing a new licensing category for CCOs. Upon certification, CCOs will be eligible to negotiate a contract with OHA for Medicaid and with OHA and CMS for dually eligible beneficiaries. The Insurance Division will also have responsibility for evaluating CCO financial reports using a combination of National Association of Insurance Commissioners forms and OHA templates, and for assuring financial solvency.

Oregon will continue to rely on external contractors for some specialized elements related to Oregon's Medicaid program, including external quality review, metrics development/technical support, Medicaid Management Information System (MMIS) technical support, and support with the pharmacy benefit. OHA is also using a contractor for technical assistance in the RFA solicitation and application review process for CCOs.

Demonstration-specific staff will also be required, including a project director to oversee the demonstration implementation and program analysts to staff and coordinate the implementation, procurement, and operations and oversight of the demonstration (see work plan in Appendix B). Demonstration-dedicated analysts from OHA will partner with DHS staff to ensure that the needs of vulnerable populations are fully met and their care effectively integrated and coordinated.

The OHA's Office of Health Analytics will organize and provide the capacity to receive, manage, and analyze Medicare and Medicaid data in support of the proposed demonstration. The Office of Health Analytics is comprised of research and actuarial staff who organize and analyze data pertaining to Oregon's health system that can be used by practitioners and policy makers both inside and outside of state government. In collaboration with other OHA divisions, staff collect and conduct statistical analyses on a wide range of data, including claims and encounters for Oregon's All Payer All Claims program, health insurance coverage, hospital and ambulatory discharge, hospital financials, health care acquired infections, and health care workforce to evaluate OHA program performance and to provide more complete picture of access, quality, cost, and utilization across Oregon's health care system.

In addition, OHA has subcontracted with outside experts in health economics, actuarial science and statistics in order to assist in the integration and analysis of Medicare and Medicaid claims data. These contractors will work to analyze Medicaid and Medicare claims data in order to identify and estimate opportunities to improve health outcomes and reduce expenditures.

Key to Oregon's model is its structure for shared accountability between CCOs and LTC system for ensuring that care for individuals receiving Medicaid-funded LTC services is coordinated and achieves Oregon's policy goals around health outcomes, quality of care, and reduced costs. Internal coordination between OHA and DHS will be critical to effectively and jointly implement shared accountability mechanisms such as contractual requirements for coordination.

- At the leadership level, the demonstration will leverage existing OHA/DHS coordination structures, including the OHA/DHS Joint Operations Steering Committee, the OHA/DHS Joint Policy Steering Committee, and the Medicaid/CHIP Operations Coordination Steering Committee.
- At the central office staff level, the demonstration will continue the joint staff work between OHA and DHS staff to develop and implement requirements for coordination, develop mechanisms for sharing data with CCOs and local LTC offices and providers, provide guidance and technical assistance for development and implementation of memoranda of understanding (MOU) between CCOs and local LTC offices, and develop accountability metrics and mechanisms for CCOs and the LTC system through a stakeholder process.
- At the local level, the demonstration will build local LTC staff capacity to engage in new activities and partnerships with CCOs, actively working to ensure the successful adoption of new shared accountability arrangements and relationships between LTC offices and providers and CCOs. In particular, regional LTC staff will develop business practices to implement MOU activities, educate and train LTC field staff to participate in MOU activities, serve as a liaison to the CCO and care planning teams, share information with CCOs about their members receiving LTC to identify high needs members, facilitate inclusion of LTC providers in care planning and coordination, offer ongoing technical assistance to troubleshoot situations that arise with CCO providers or individuals served by the CCO and LTC systems, oversee local staff efforts and collect information for evaluation activities, develop lessons learned materials and share best practices, successful approaches and challenges, and facilitate the review and updates of MOUs between CCOs and local LTC offices.

Development of metrics and accountability mechanisms for the purposes of the demonstration will be a joint effort between OHA and CMS, leveraging OHA work and expertise related to CCO metrics and accountability for Medicaid, as well as DHS work and expertise in oversight of the LTC system. Public comments on the draft proposal included specific recommendations for monitoring implementation, including a focus on prospective monitoring and on consumer experience. These comments, as well as ongoing stakeholder engagement, will help to inform the work to develop appropriate monitoring approaches.

Communications staff will develop outreach and communication strategies to stakeholders, materials for notifying members of enrollment, and materials for CCOs to use in their member materials. Office of Information Systems staff will lead work to implement technology solutions needed to carry out the demonstration, as well as new technology solutions to enable new sharing of DHS/OHA client-level data with CCOs related to their members and provide new population management and care coordination tools and record systems for individuals served by CCOs and by our DHS programs.

Need for waivers

OHA anticipates that there may be a need for flexibility around current Medicaid rules and requirements related to appeals in order to align the process with Medicare, and related to actuarial soundness if required for the blended payment rate, and OHA looks forward to working with CMS to determine if any waiver of rules is needed in this area.

For Medicare, areas where it is anticipated that there may be a need for flexibility include:

- Enrollment requirements, to allow passive enrollment;
- Appeals alignment;
- Marketing rules/restrictions;
- Quality measures and reporting, including flexibility on required measures and topics for performance improvement plans;
- Billing rules to align with Medicaid;
- Waiving 3-day prior hospital stay requirement for Skilled Nursing Facility (SNF) benefit; and
- Allowing SNF benefit to be offered in other settings such as community based care facilities.

Plans to expand to other service areas

Oregon expects the demonstration to serve the majority of dually eligible individuals from the start of the demonstration, depending on CCO interest in participating in the demonstration. Oregon does not anticipate a need to expand the service area of the demonstration after the start date in 2014.

Overall implementation strategy and anticipated timeline

Implementation of the demonstration will follow the implementation of the overall CCO model, which is already underway. Key steps in the process for implementation of the demonstration will include:

- CCO certification and procurement for Medicaid
- Actuarial analysis and rate-setting
- Development of quality metrics and outcomes targets
- IT/systems adaptations
- Communications, training, technical assistance
- LTC shared accountability implementation
- State regulatory changes
- Contract monitoring and compliance
- Quality monitoring and evaluation
- Implementation of pilots

OHA is in the process of initiating the procurement for the overall Medicaid CCO contracts, and the CMS process will follow the OHA process. See Appendix B for a more detailed work plan and timeline. OHA agrees to collect and/or provide data to CMS to inform program management, rate development, and evaluation, including beneficiary level information, and a description of any policy changes to the Medicaid State Plan in the state that would affect dually eligible enrollees (such as payment rate changes, benefit design, and the addition or expiration of waivers).

H. Feasibility and Sustainability

Potential barriers/challenges and/or future state actions that could impact implementation

As mentioned above in Section E, OHA is concerned about finding a rate that will work in Oregon, given Oregon's mature managed care delivery system. CMS proposes to base rates on historical spending – in both fee for service (FFS) Medicare and Medicare Advantage – and then to take savings out of the rate prospectively, with a three year demonstration period to realize net savings. Medicare Advantage plans in Oregon have already realized many efficiencies, yet FFS Medicare costs in Oregon are significantly

lower, potentially due in part to lack of access to care in FFS Medicare. Oregon's 2009 Physician Workforce Survey found that 19 percent of primary care physicians refused to take any new Medicare beneficiaries, and 6.5 percent refused to take FFS Medicare beneficiaries although they accept Medicare Advantage enrollees, in large part due to low rates.[17] In addition, CMS's financial model for the demonstration may not reflect the costs of supplemental benefits which beneficiaries may already be receiving through Medicare Advantage. While there are additional savings to be found through this model, the widespread system change envisioned in Health System Transformation will take initial investments and the time to play out. To address this challenge, OHA will work closely with CMS and with interested plans to find an approach to rate setting that works in Oregon.

OHA's CCO procurement timeline precedes the demonstration procurement process. OHA's Request for Applications (RFA) was released in March, and 14 CCO applications were received for the first wave application deadline on April 30. Since the demonstration procurement will not begin until the fall of 2012, and will be separate from the CCO procurement, CCOs may be asked to provide information which duplicates the information already provided in their CCO application. OHA's goal is to create as integrated a procurement process for the demonstration as possible, such that OHA and CMS requirements do not duplicate each other, and building on the information previously submitted, to the greatest extent possible. Since part of the reason that the decision was made to have a 2014 start date for the demonstration was a concern that the demonstration parameters and application requirements for plans were not fully known before the procurement process started, OHA will also work to ensure that this information is finalized and available to plans before they must decide whether to apply to participate.

Balancing these barriers are many forces in our favor: executive level support of this model of health reform, dedicated state staff, and fit of this proposal within Oregon's larger health reform.

Remaining statutory/regulatory changes needed for implementation

As previously mentioned, Oregon's legislature passed Senate Bill 1580 on February 23, 2012, authorizing the OHA to implement CCOs. The state put into place temporary rules in March 2012, related to CCOs and the new procurement process for CCOs. Many of the changes necessary in state rules to implement the demonstration are included in these rules, but there may be additional rules changes that are necessary to move forward with the demonstration. These rule changes will be either included in the permanent rules process in September, or will be handled through a separate temporary rules process. OHA does not anticipate that any further statutory changes will be necessary.

New funding commitments/contracting needed for implementation

OHA officially began the CCO procurement process by posting the RFA on March 19, 2012. The RFA described the criteria outlined in this proposal that organizations must meet to be certified as a CCO. The request for applications is be open to all communities in Oregon and will not be limited to certain geographic areas. Entities will be able to apply to become CCOs in four waves; the first wave of applications was due April 30 for a CCO start date of August 1, and the following three waves follow similar application timelines with start dates of September 1, October 1, and November 1. After applications are received, OHA will review and award certification to eligible CCOs. OHA is currently in the process of reviewing the first round of 14 applications. Certified CCOs will be eligible for negotiated

[17] Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP), "2009 Physician Workforce Survey," May 2010 available at http://www.oregon.gov/OHA/healthplan/data_pubs/reports/pws-2009.pdf?ga=t (accessed March 2, 2012)

Medicaid contracts. As noted previously, the CMS/OHA joint procurement process for participation in the demonstration will follow the overall CCO procurement process and will begin in fall 2012.

In support of the CCO procurement process, Oregon will rely on two new sources of federal funding to implement Health System Transformation. First, Oregon anticipates receiving implementation funding related to this proposal; such funding will be critical to effectively integrate Medicare and Medicaid for individuals dually eligible via CCOs. Secondly, Oregon has an agreement in principle with CMS to obtain new Medicaid funding for previously unmatched state program expenditures, under the federal Designated State Health Programs effort. The resulting $1.9 billion in funding over five years will allow Oregon to invest in the substantial development activities needed to ensure effective implementation of Oregon's Health System Transformation for all Medicaid and dually eligible beneficiaries.

Scalability/replicability of proposed model

With the OHP, early work towards establishing a health insurance exchange, and a legislatively approved blueprint for Health System Transformation, Oregon has a track record of being in the forefront of health reform. The CCO model will be implemented statewide in Oregon, and the approach, with its focus on local community needs assessment and accountability for outcomes, will be widely replicable in other areas around the country. This model squarely targets the Triple Aim and allows communities to move beyond addressing the low-hanging fruit where one-time cost savings can be realized to fundamentally realign the health system to achieve desired health outcomes while reining in cost growth. This type of system transformation and bending the cost curve is a promising direction for the rest of the country to move in, and the model being developed in Oregon will demonstrate how it can be replicated in other states.

I. CMS Implementation Support—Budget Request

Oregon requests funding for the following elements to support the development of state infrastructure necessary to implement the demonstration proposed in this document:

- Staffing and administrative costs
- Communications, training, and TA:
    - Beneficiary outreach and education activities
    - Marketing and outreach - targeted and broad outreach to members and providers
- Health analytics and accountability (data, metrics, actuarial analytics)
- Program implementation/operations
- Information Technology, including
    - Systems change costs to implement HST (e.g., enrollment systems changes)
    - Improving exchange of information for care coordination purposes (e.g., sharing client information about entry into LTC or about 7-11 drugs with CCOs)
    - Improved/new data collection mechanisms/systems
- Integrated Care Pilots

Oregon will not use any implementation funds awarded as a result of this proposal for service costs or to draw down Federal match.

J. Additional Documentation (as applicable)

See Appendices for additional documentation and resources.

K. Interaction with Other HHS/CMS Initiatives

Partnership for Patients: Health System Transformation in Oregon is closely aligned with the two major goals of the Partnership for Patients initiative: helping people heal without complication and preventing people from getting injured or sicker. For example, CCOs must develop a transitional care approach that uses established or best practices approaches to transitional care management. PCPCHs will provide organized team based care where up-to-date, accurate member information is shared and relevant follow-up services are provided during transitions of care or across providers of care. Keeping people from getting sicker is in alignment with Oregon's goals, and accountability structures developed for CCOs include related outcomes, such as metrics for hospital healthcare acquired conditions. CCO learning collaboratives, once implemented, are expected to include sharing best practices related to both transitional care and reducing preventable hospital-acquired conditions.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities: Health equity and identifying and addressing health disparities are key components of Health System Transformation in Oregon and consistent with the vision of the Department of Health and Human Services (HHS) disparities action plan: A nation free of disparities in health and healthcare. CCO assessments, strategies, and action plans for addressing health disparities to foster health equity are also in alignment with the strategic goals and key actions set forth by HHS in the Disparities Action Plan.

CCOs will promote better collaboration, efficiencies and accountability for minority health and health disparities through a variety of assessment and reporting mechanisms. CCOs are expected to conduct, in collaboration with community partners, a community health assessment to identify health disparities associated with race, ethnicity, language, health literacy, age, disability status, gender, sexual orientation, geography, or other factors in its service area. Based on this assessment and on priorities developed by the CCO community advisory council and community partners, each CCO will develop a community health improvement plan to address health needs and reduce health disparities. CCOs are also expected to collect or maintain race, ethnicity, and primary language data for all members on an ongoing basis, such that quality measures can be tracked by these demographic factors.

CCOs are expected to utilize best practices of culturally appropriate care. Through the use of PCPCHs, CCOs will improve access to health care for underserved communities. In their application, CCOs must describe what actions they have taken to assure that PCPCHs are accessible to families, diverse communities, and underserved populations and to utilize community health workers, health navigators and qualified health interpreters in providing culturally appropriate, whole-person care.

Million Hearts Campaign: The approach to CCO structure, service provision and accountability is well aligned with the Million Hearts campaign to prevent one million heart attacks or strokes. CCOS are expected to improve access to coordinated, team based care using evidence based disease management approaches, particularly for high needs members, as well as to leverage the effectiveness of non-traditional healthcare workers in promoting wellness through early intervention and prevention and tools for self-management of chronic disease. CCO performance measures are aligned with key quality indicators outlined in the Campaign such as monitoring tobacco cessation. CCOs are also expected to share results from their efforts to manage chronic diseases and develop prevention and wellness efforts through a learning collaborative approach.

Appendix A: Additional Documentation and Resources

Oregon documentation and resources relevant to this proposal:

Health System Transformation resources:

- Oregon's Request for Applications (RFA) re: Coordinated Care Organizations: http://cco.health.oregon.gov
- List of first wave CCO Applicants: https://cco.health.oregon.gov/Pages/CCO-Applicant-Names.aspx
- List of entities that filed a Letter of Intent to submit a CCO application: https://cco.health.oregon.gov/Pages/CCO-Applicant-Names.aspx
- Oregon's 1115 waiver request (submitted to CMS March 1, 2012): http://cco.health.oregon.gov
- Oregon Health Policy Board, Coordinated Care Organizations Implementation Proposal to the Legislature, January 24, 2012: http://health.oregon.gov/OHA/OHPB/health-reform/docs/cco-implementation-proposal.pdf
- Oregon's Patient-Centered Primary Care Home standards: www.primarycarehome.oregon.gov

Shared accountability for long term care:

- Strategic Framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care, February 10, 2012 http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf
- Report for House Bill 5030 (2011) Budget Note on Oregon's Long Term Care System, January 2012 http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/docs/ltc-budget-note-rpt.pdf
- OHA/DHS Guidance on LTC Memorandum of Understanding (MOU) http://www.oregon.gov/DHS/hst/apd-cco-info.shtml

Input from dually eligible individuals and community members:

- Oregon Listening Session Final Report, February 2012: http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-oregon-listening.pdf
- Oregon CMS Beneficiary Focus Groups Report (Thomson Reuters) Summer 2011: http://health.oregon.gov/OHA/OHPB/health-reform/docs/2011-1019-focus-grp.pdf
- OHA Community Meetings Summary, September - October 2011: http://www.oregon.gov/OHA/OHPB/meetings/2011/2011-1108-com-mtgs.pdf

Draft Demonstration Proposal

- Draft proposal and public comments: https://cco.health.oregon.gov/Pages/Medicare-Medicaid-Proposal.aspx

Relevant legislation:

- Senate Bill 1580, 2012 session: www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.intro.pdf
- House Bill 3650, 2011 session: http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.intro.pdf

Websites:

- Oregon's Health System Transformation and Oregon Health Policy Board (OHPB): http://health.oregon.gov/
- OHPB: Medicare-Medicaid Integration of Care and Services Workgroup: http://health.oregon.gov/OHA/OHPB/health-reform/workgroups/medicare-medicaid-integration.shtml

CMS guidance and resources:

- State Medicaid Director Letter, 11-008, Financial Models to Support State Efforts to Integrate Care for Medicare- Medicaid Enrollees, July 8, 2011: https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
- CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans, January 25, 2012: https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf
- CMS Financial Alignment Initiatives website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html
- CMS State Demonstrations to Integrate Care for Dual Eligible Individuals – Design Contracts website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html

Other resources:

- Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." September 2011, available at http://www.longtermscorecard.org/~/media/Files/Scorecard%20site/Report/AARP_Reinhard_Realizing_Exp_LTSS_Scorecard_REPORT_WEB_v4.pdf.
- Segal, Misha "Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations." September 2011, available at https://www.cms.gov/Insight-Briefs/downloads/PAHInsightBrief.pdf.

Appendix B: Work plan/Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
	Demonstration proposal	
April 2011-February 2012	Develop CCO and demonstration approaches	OHA
June 2011-April 2012	Stakeholder engagement on CCO and demonstration approaches	OHA
March 5 - April 13, 2012	Public comment period on draft proposal	Stakeholders
May 11, 2012	Submission of final proposal to CMS	OHA
May-June 2012	CMS 30-day public comment period	CMS
	Memorandum of Understanding (MOU) with CMS	
June 2012	Identify Medicaid waivers or State Plan Amendments needed	OHA/CMS
Summer 2012	Submit waiver and/or SPA as needed	OHA
Fall 2012	Waiver/SPA approval if needed	CMS
May-August 2012	Develop MOU with CMS	OHA/CMS
August/September 2012	Finalize MOU with CMS	OHA/CMS
	Actuarial analysis and rate setting	
Winter 2011-Summer 2012	CMS sends OHA historical and ongoing Medicare data	CMS
May-July 2012	Analysis of integrated Medicare/Medicaid data to inform rate development, including identifying scale of savings estimates	OHA
May-July 2012	Actuarial analysis for rate development	OHA
June-August 2012	Work with CMS to develop rate parameters	OHA/CMS
August/September 2012	Finalize initial demonstration rates	
Spring/Summer 2013 and annually	Update demonstration rates	OHA/CMS
	CCO certification and procurement for Medicaid (first wave applicants)	
March 5-13, 2012	Draft RFA, model contract, temporary rules posted for public input	OHA
March 2012	Temporary rules filed	OHA
March 19, 2012	CCO Medicaid RFA posted	OHA/CCO
April 2, 2012	Letters of Intent due to OHA	CCO
April 30, 2012	Technical Application due	CCO
May 14, 2012	Financial Application due	CCO

Timeframe	Key Activities/Milestones	Responsible Parties
May 29, 2012	New CCOs awarded certification	OHA
June 14, 2012	Medicaid contract signed	OHA/CCO
June 15, 2012	Medicaid contract to CMS	OHA
June 25, 2012	Readiness review documentation due	CCO
July 16, 2012	Notice to proceed	OHA
August 1, 2012	Medicaid contract effective	OHA
	Regulatory framework	
Spring 2013	Identify additional new regulations and changes to existing regulations if needed	OHA
Summer-Fall 2013	Develop and promulgate regulations	OHA
	Develop quality metrics and outcomes targets	
	<u>Metrics for Medicaid:</u>	
Fall 2011-Spring 2012	Develop initial quality metrics list for Medicaid	OHA
Summer 2012 - ongoing	Technical Advisory Group to develop specifications for each quality metric	OHA
Fall 2012	Metric collection and analysis plan	OHA
Fall 2012	Measurement/reporting systems in place	OHA
CY2013	CCO performance reporting begins	OHA/CCO
Summer 2013	Review initial performance data, develop any additional/changes to metrics list, develop benchmarks	OHA
CY2014	CCO accountability for performance begins	OHA/CCO
	<u>Additional metrics for demonstration:</u>	
Summer 2012	Develop initial, additional demonstration quality metrics	OHA/DHS/CMS
Summer 2012 - ongoing	Technical Advisory Group to develop specifications for each quality metric	OHA
Fall 2012-Summer 2013	Metric collection and analysis plan	OHA/DHS/CMS
Fall 2013	Measurement/reporting systems in place	OHA/DHS/CMS
CY2014	Demonstration plan reporting begins	OHA/DHS/CCO
	Accountability: Contract monitoring and compliance	
Ongoing	Design mechanisms for CCO contractual accountability for performance on metrics for Medicaid and for demonstration	OHA/DHS/CMS
CY2014	CCO accountability for performance begins	OHA/DHS/CCO
Ongoing	Ongoing monitoring for CCO/demonstration plan compliance	OHA/DHS
Ongoing	Monitoring/evaluation of demonstration	OHA/DHS/CMS

Timeframe	Key Activities/Milestones	Responsible Parties
	Shared accountability for LTC	
Spring-Summer 2012	Requirements for CCOs/LTC system to coordinate: • Included in CCO RFA, rules, contract • Included in APD policies/AAA intergovernmental agreements • Included if needed in LTC provider rule	OHA/DHS
	Memorandum of Understanding (MOU) between CCOs/LTC local offices:	
April 2012	• Guidance published	OHA/DHS
July 1, 2012	• Complete initial MOU due for first wave CCOs	CCOs/LTC
Ongoing	• Technical assistance, monitoring and evaluation	DHS/OHA
	CCO metrics and financial accountability for LTC:	
(see above section)	• (see **Develop quality metrics** and **Accountability** sections above)	(see above)
	LTC system metrics and financial accountability:	
Summer-Fall 2012	• Develop initial quality metrics list for LTC system, leveraging CCO initial metrics where appropriate	DHS/OHA
Fall 2012	• Technical Advisory Group to develop specifications for each quality metric	TAG
CY2013	• Performance data reporting begins, aggregated by system and provider type	OHA/DHS/LTC
Summer 2013-2014	• Design mechanisms for LTC system accountability for performance on metrics for Medicaid and for demonstration, using stakeholder process	DHS/OHA
CY2015	• LTC system accountability for performance begins	OHA/DHS/LTC
January -March 2013	Regional LTC staff development (hiring, training)	DHS
	Demonstration procurement	
Fall 2012	Draft and release procurement materials	OHA/CMS
November 2012	Notice of Intent to Apply due	CCOs
Spring 2013	Demonstration applications and associated materials (e.g., Part D formulary, benefits) due	CCOs
Summer 2013	Select demonstration plans	OHA/CMS
August/September 2013	Conduct demonstration plan readiness reviews	OHA/CMS
September 2013	Execute contracts/demonstration plans approved for enrollment	OHA/CMS
	Communications, Training, TA	
Summer 2013	Develop outreach/marketing materials	OHA
Summer/Fall 2013	Develop model demonstration plan beneficiary materials	OHA/CMS

Timeframe	Key Activities/Milestones	Responsible Parties
Summer-September 2013	Identify and train operational/field staff to work with beneficiaries around options for enrollment and passive enrollment	OHA/DHS
Summer-September 2014	Training/communication of OHA/DHS staff on shared accountability for LTC accountability mechanisms	OHA/DHS
Ongoing	Technical assistance to plans	OHA
Ongoing	Ongoing stakeholder meetings/outreach	OHA/DHS
	Technology	
Spring-Fall 2013	Update MMIS enrollment systems to account for passive enrollment/opt out, and update payment systems to account for blended payments to CCOs	OHA/OIS
Sumer 2012-Fall 2013	Technology solution for sharing OHA/DHS data with CCOs	OHA/DHS/OIS
Fall 2012-Fall 2013	Population management/coordination of care tools for CCOs	OHA/DHS/OIS
Fall 2012-Fall 2013	Implement new data collection mechanisms (EHR/HIE)	OHA/DHS/OIS
	Integrated care pilots	
November/December 2012	Identify potential pilot participants, develop planning and development contracts	OHA/DHS and participants
January 2013	Pilot contracts executed, pilot planning/development begins	OHA/DHS and participants
Spring 2013	Draft PACE waivers/agreements	DHS
January 2014	Launch pilots: Open PACE in expansion areas, begin Housing with Services program	OHA/DHS and participants
	Enrollment into Demonstration plans	
October 2013	Beneficiary notification/communications	OHA/CMS
October 2013-February 2014	Intensive operational/field staff work with beneficiaries around enrollment	OHA/DHS
October 2013 - ongoing	Opt out beneficiaries not enrolled	OHA/CMS
January 1, 2014	***Demonstration start***	

Appendix C: List of Acronyms

AAA	Area Agency on Aging
APAC	All Payer All Claims program
APD	Division of Aging and People with Disabilities (within DHS)
CCO	Coordinated Care Organization
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Human Services (Oregon)
DMAP	Division of Medical Assistance Programs (within OHA)
FFS	Fee-for-service
HCBS	Home and Community Based Services
HHS	Department of Health and Human Services (Federal)
I/DD	Intellectual or developmental disabilities
LTC	Long Term Care
MMIS	Medicaid Management Information System
OEBB	Oregon Educational Benefits Board
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OHPB	Oregon Health Policy Board
PACE	Program of All-Inclusive Care for the Elderly
PCPCH	Patient-Centered Primary Care Home
PDL	Preferred Drug List
PEBB	Public Employees Benefits Board
RFA	Request for Applications
SPMI	Severe and Persistent Mental Illness

Appendix D: Initial Proposed CCO Accountability Metrics (transparency metrics also listed)

Table C-1
Year 1 CCO Accountability and Transparency Metrics
Excerpt from Oregon Health Authority (OHA) Final Request for Proposals, March 2012

Note: CCOs' accountability in Year 1 is for reporting only - reporting encounter data or reporting on measures under the second heading below. Because accountability is for reporting only, measures are not categorized into "core" or "transformational." The OHA Metrics & Scoring Committee (established by SB 1580) will advise the Authority on development of benchmarks, accountability structure, and incentive design for future years.	**Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.**
Measures to be collected by OHA and CCOs **1. Reduction of disparities - report all other metrics by race and ethnicity** *Data collection responsibility*: OHA collection of race and ethnicity at enrollment; responsibility for reporting by race and ethnicity depends on specific measure *Measure also collected or required by*: n/a Measures to be reported by OHA or contractor, validated with CCOs **1. Member/patient Experience of care (CAHPS tool or similar)**^* *Data collection responsibility:* OHA *Measure also collected or required by:* Medicaid (Adult Core and CHIPRA Core); Medicare Advantage and ACOs; OR PCPCH; others **2. Health and Functional Status among CCO enrollees**^* *Data collection responsibility:* OHA, at enrollment and reauthorization or via member survey *Measure also collected or required by:* n/a **3. Rate of tobacco use among CCO enrollees**^* *Data collection responsibility:* OHA, at enrollment and reauthorization or via member survey *Measure also collected or required by:* n/a **4. Obesity rate among CCO enrollees**^* *Data collection responsibility:* OHA collection of height, weight via member survey *Measure also collected or required by:* n/a **5. Outpatient and ED utilization**^* *Data collection responsibility: OHA or contractor via encounter data* *Measure also collected or required by: Medicaid (CHIPRA Core)*	CMS Medicaid Adult Core Measures including: Flu shots for adults 50-64 Breast & cervical cancer screening Chlamydia screening Elective delivery & antenatal steroids, prenatal and post-partum care Annual HIV visits Controlling high BP, comprehensive diabetes care Antidepressant and antipsychotic medication management or adherence Annual monitoring and for patients on persistent medications Transition of care record CMS CHIPRA Core Measures including: Childhood & adolescent immunizations Well child visits Appropriate treatment for children with pharyngitis and otitis media Annual HbA1C testing Utilization of dental, ED care (including ED visits for asthma) Pediatric CLABSI Follow up for children prescribed ADHD medications

6. Potentially avoidable ED visits^* *Data collection responsibility:* OHA or contractor via encounter data *Measure also collected or required by:* QCorp **7. Ambulatory care sensitive hospital admissions (PQIs)**^* *Data collection responsibility:* OHA or contractor via encounter data *Measure also collected or required by:* Medicaid (Adult Core); Medicare ACOs; Q-Corp **8. Medication reconciliation post discharge**^* *Data collection responsibility: OHA or contractor via encounter data (use measure administrative specifications)* *Measure also collected or required by: Medicaid (CHIPRA Core)* **9. All-cause readmissions**^* *Data collection responsibility: OHA or contractor via encounter data* *Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs; Q-Corp* **10. Alcohol misuse – screening, brief intervention, and referral for treatment**^ *Data collection responsibility: OHA or contractor via encounter data Measure also collected or required by: Medicaid (Adult Core); Meaningful Use, OR PCPCH* **11. Initiation & engagement in alcohol and drug treatment**^ *Data collection responsibility:* OHA or contractor via encounter data *Measure also collected or required by:* Medicaid (Adult Core); Meaningful Use, OR PCPCH **12. Mental health assessment for children in DHS custody** *Data collection responsibility:* OHA via encounter and administrative data *Measure also collected or required by:* Current MHO performance measure/ DHS wraparound initiative **13. Follow-up after hospitalization for mental illness**^ *Data collection responsibility: OHA or contractor via encounter data* *Measure also collected or required by: Medicaid (Adult Core)* **14. Effective contraceptive use among women who do not desire pregnancy*** *Data collection responsibility:* OHA via member survey *Measure also collected or required by:* Medicaid (Adult Core) **15. Low birth weight** *Data collection responsibility:* OHA or contractor via encounter or vital statistics data *Measure also collected or required by:* Medicaid (CHIPRA Core)	SAMSHA National Outcome Measures including: Improvement in housing (adults) Improvement in employment (adults) Improvement in school attendance (youth) Decrease in criminal justice involvement (youth) Others TBD, for example: Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc. Initiation and engagement of mental health treatment

16. Developmental Screening by 36 months
Data collection responsibility: OHA or contractor via encounter data, (use measure administrative specifications)
Measure also collected or required by: Medicaid (CHIPRA Core)

Measures to be collected by CCOs or EQRO

1. Planning for end of life care (documentation of wishes for members 65+)
Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
Measure also collected or required by: n/a

2. Screening for clinical depression and follow-up^
Data collection responsibility: CCOs or via EQRO; could be sample rather than population-based
Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs

3. Timely transmission of transition record^
Data collection responsibility: CCOs or via EQRO; could be sample-rather than population-based
Measure also collected or required by: Medicaid (Adult Core, Health Homes Core); AMA-PCPI

4. Care plan for members with Medicaid-funded long term care benefits
Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
Measure also collected or required by: n/a – to promote coordination with long term care services

*Report separately for members with severe and persistent mental illness
^ Report separately for individuals with Medicaid-funded Long Term Care (LTC)
– These measures may be used to promote shared accountability between CCO and LTC systems.

Appendix E: Summary of Outreach during Proposal Development

Oregon obtained significant beneficiary and other stakeholder feedback throughout the process of planning for Health System Transformation, CCO implementation, and this demonstration proposal in particular. These efforts have included: (1) OHPB meetings, workgroups, and public comment; (2) the OHPB's Medicare-Medicaid Integration of Care and Services Work Group; (3) OHA's Health System Transformation Community Meetings; (4) Medicare and Medicaid Integration Sub Group/HB 5030 Budget Note; (5) CMS beneficiary focus groups; (6) OHA's Dual Eligible Beneficiary Listening Groups; (7) PCPCH development stakeholder groups; and (8) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 60 public meetings in total leading up to the development of the overall CCO implementation proposal and this demonstration proposal. Appendix A includes links to the final products related to these efforts.

Oregon Health Policy Board: The OHPB is responsible for oversight of Health System Transformation and the development of the CCO Implementation Proposal to the Legislature. HB 3650 required OHA to develop a proposal to implement CCOs, which was ultimately submitted to the legislature on January 24, 2012. The implementation proposal was developed through the Oregon Health Policy Board and is the result of the work of the board and four work groups comprising 133 people who met over four months, a series of eight community meetings around the state that brought input from more than 1,200 people, invited testimony and public comment at the monthly Board meetings. One of those four workgroups was the Medicare - Medicaid Integration of Care and Services group mentioned below.

Governor-appointed Medicare-Medicaid Integration Work Group: The Medicare-Medicaid Integration of Care and Services group consisted of 30 members representing beneficiaries, providers, advocates and other stakeholders. The Work Group met once per month between August-November, 2011. In concert with the three other Health System Transformation work groups, the Work Group considered CCO criteria, global budget, outcomes and metrics, shared accountability with LTC, and other topics. In addition to ensuring that the other work groups considered factors uniquely or disparately impacting individuals who are dually eligible, the Work Group also evaluated administrative and regulatory disconnects between the Medicare and Medicaid programs. After each Work Group meeting, meeting materials were posted to the website and a public input period was opened to solicit feedback. This feedback was circulated to both the Work Group and OHA staff. The Work Group's recommendations were sent to the OHPB for discussion at their monthly public meetings. Public comment was also allowed at the Board meetings. The Board considered and included Work Group recommendations and public feedback into the Board's CCO Implementation Proposal.

HB 5030 Budget Note Subgroup of Medicare-Medicaid Work Group: A nine member Sub Group of the larger Medicaid Integration of Care and Services Work Group was established in response to a legislative budget note attached to House Bill 5030. The group was tasked to address two questions through the lens of Oregon's Health System Transformation efforts:

1) 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 and families.

2) 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.

The Sub Group met four times between October and December 2011. Recommendations of this group were reflected in the HB 5030 Budget Note Report to Legislature, and formed the basis of the strategies for CCO/LTC system coordination and shared accountability that are incorporated into this proposal.

Medicare-Medicaid Focus Group: During the week of July 18, 2011, CMS' Medicare-Medicaid Coordination Office sponsored a series of focus groups around the state with Oregonians dually eligible for Medicare and Medicaid. Six focus groups were held in The Dalles, Portland and Roseburg. OHA staff observed and provided feedback on all groups. Questions were designed to gain insight into current experiences of care, system navigation, care coordination, and priorities for system improvement. Key findings included: wide-spread access to primary care but still frequent emergency department utilization; high specialist and prescription drug utilization; and frequent disconnects between medical care and social support systems.

OHA Beneficiary Listening Group: OHA conducted listening groups with dually eligible individuals and their caregivers during the week of December 12, 2011. The Listening Groups were designed to gain beneficiary input and feedback on the key recommendations coming out of the four OHPB work groups. OHA targeted five communities within the state: Portland, Eugene, Bend, Roseburg; and Coos Bay. These communities were chosen because of their large population of individuals who are dually eligible as well as indications that they were more likely to be among the earliest communities to implement CCOs. Taking into consideration recommendations from the four OHPB work groups, OHA staff developed questions focused on garnering feedback on strategies that would impact beneficiaries, including: improved care coordination; individual care planning, and health care coordinators and other new roles. Participants indicated strong support for many of the proposed strategies, including: making care more person-centered; individual participation in care planning; improved coordination and communication among providers; and "single point-of-contact" roles within the health care system that could help with navigation and advocacy. Groups were facilitated by Alice Lind from the Center for Health Care Strategies.

Patient-Centered Primary Care Home Development: The Oregon Legislature established the PCPCH Program in 2009 through passage of House Bill 2009. The program staff worked with diverse groups of Oregonians from across the state, the PCPCH Standards Advisory Committees, to define what a primary care home looks like. The first PCPCH Standards Advisory Committee was made up of a diverse group of Oregon stakeholders including patients, clinicians, health plans and payers. Over the course of seven meetings between October 2009 and January 2010, the committee developed the six core attributes and a number of standards that describe the care that should be delivered by primary care homes. The committee also developed a set of detailed PCPCH measures that assess the degree to which clinics are functioning as primary care homes – Tier 1, Tier 2, or Tier 3. In the fall of 2010 the PCPCH Pediatric Advisory Committee convened to further refine the standards to ensure the unique needs of children and adolescents were captured. Beginning in 2011, the PCPCH Program, in partnership with the Northwest Health Foundation, convened a task force to provide recommendations to support broad implementation of the primary care home model across Oregon. The task force membership included clinicians, patients, public health, and healthcare delivery technical experts from across Oregon. The program is now working to implement the recommendations of the task force, and administer the application, recognition, and verification process for practices applying to become PCPCHs.

Other Stakeholder Engagement: Finally, throughout OHA's development of its integration proposal, staff have engaged stakeholders to gain both insight and feedback. This outreach has included meeting with advisory councils, including Oregon's Medicaid Advisory Council, committees and other stakeholders around the state, including: health insurers currently covering individuals who are dually eligible; AAA directors; APD district managers; seniors and people with disability advocates; and providers. Discussions were designed to solicit feedback on recommendations and questions coming from Work Group and OHA staff inquiries and recommendations. In summary, assistance and participation from stakeholders proved invaluable in the design and development of this proposal.

Oregon Health System Transformation Public Process 2011-2012

Date	Meeting
Jan. 18, 2011, 9 am–4 pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 2, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team
Feb. 8, 2011, 1-3:30 pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 9, 2011, 6-9 pm	Public meeting: Weekly Health System Transformation Team
Feb. 11, 2011, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Feb. 23, 2011, 6-9 pm	Tribal Health Services: SB 770 Meeting
Feb. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 2, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 8, 2011, 8:30 am-noon:	Oregon Health Policy Board meeting; public comment accepted
Mar. 9, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 16, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 6-9 pm:	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 9 am-noon	Medicaid Advisory Committee
April 12, 2011, 12:30-4:30 pm	Oregon Health Policy Board meeting; public comment accepted
May 5, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
May 10, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
April 27, 2011, 9 am - noon	Medicaid Advisory Committee
April 29, 2011, 9 - 10 am	Tribal Consultation
May 16, 2011 9 - 10 am	Tribal Consultation
May 25, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
June 2, 2011, 9-10 am	Tribal Consultation
June 2, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
June 23, 2011, 10-11 am	Oregon Health Policy Board meeting; public comment accepted
June 29, 2011	Senate passes House Bill 3650 by a vote of 22-7
June 30, 2011	House passes House Bill 3650 by a vote of 59-1
July 1, 2011	Governor Kitzhaber signs House Bill 3650, providing a framework for Coordinated Care Organizations and launching four workgroups and next round of public comments

Date	Meeting
July 12, 2011, 8 am-1 pm	Oregon Health Policy Board meeting; public comment accepted
July 18, 1211	CMS/Thomson Reuters Focus Groups with Dually Eligible Oregonians – The Dalles
July 19, 2011, 2 to 3 pm	Tribal Consultation
July 19, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Portland (2 groups)
July 20, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Portland
July 21, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Roseburg (2 groups)
July 27, 2011, 9 am - noon	Medicaid Advisory Committee
Aug.4, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Aug. 9, 2011, 1-4:30 pm	Oregon Health Policy Board meeting; public comment accepted
Aug. 16, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Aug. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Aug. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Aug. 22, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Aug. 24, 2011, 9:30 am–2:30 pm	Tribal Health Services: SB 770 Meeting
Sept. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Sep. 13, 2011, 8-12:30 pm	Oregon Health Policy Board meeting; public comment accepted
Sep. 20, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Sep. 21, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Sep. 22, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Sept. 22, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Sep. 26, 2011, 9 am-noon	Public Work Group: Metrics
Sep. 26, 2011, 6-8 pm	Community meeting: Roseburg
Sep. 27, 2011, 6-8 pm	Community meeting: Medford
Sept. 28, 2011, 9 am-noon	Medicaid Advisory Committee
Oct. 3, 2011, 6-8 pm	Community meeting: Pendleton
Oct. 5, 2011, 6-8 pm	Community meeting: Florence
Oct. 6, 2011, 6-8 pm	Community meeting: Bend
Oct. 10, 2011, 6-8 pm	Community meeting: Portland
Oct. 11, 2011, 1-5 pm	Oregon Health Policy Board meeting; public comment accepted
Oct. 12, 2011, 6-8 pm	Community meeting: Eugene
Oct. 13, 2011, 6-8 pm	Community meeting: Astoria
Oct. 17, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Oct. 17, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Oct. 18, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Oct. 19, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Oct. 26, 2011, 9 am-noon	Medicaid Advisory Committee
Nov. 1, 2011, 1-4 pm	Medicare-Medicaid / Long Term Care Integration Sub-Group

Date	Meeting
Nov.3, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Nov. 8, 2011, 8:30 am-noon	Oregon Health Policy Board meeting; public comment accepted
Nov. 9, 2011 3:30-4:30 pm	Tribal Consultation
Nov. 14, 2011 1-5 pm	Tribal Health Services: SB 770 Meeting
Nov. 14, 2011, 6-9 pm	Public Work Group Meeting: Global Budget
Nov. 14, 2011, 9 am-noon	Public Work Group Meeting: Metrics
Nov. 15, 2011, 6-9 pm	Public Work Group Meeting: CCO Criteria
Nov. 16, 2011, 8-11 am	Legislature: Interim Joint Health Care Committee hearing
Nov. 17, 2011, 6-9 pm	Public Work Group Meeting: Medicare-Medicaid Integration
Nov. 30, 2011, 10:30-11:30 am	Tribal Consultation
Nov. 30, 2011, 1-4 pm	Medicare-Medicaid / Long Term Care Integration Sub-Group
Dec. 1, 2011, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Dec. 7, 2011, 1-4 pm	Medicare-Medicaid / Long Term Care Integration Sub-Group
Dec, 12, 2011, 2-4 pm	Medicare-Medicaid Beneficiary Listening Group - Portland
Dec. 13, 2011, 1-6 pm	Oregon Health Policy Board meeting; public comment accepted
Dec. 14, 2011, 1-3pm	Medicare-Medicaid Beneficiary Listening Group - Eugene
Dec. 15, 2011, 10 am–Noon	Medicare-Medicaid Beneficiary Listening Group - Bend
Dec. 15, 2011, 9 – 11 am	Medicare-Medicaid Beneficiary Listening Group - Roseburg
Dec. 15, 2011, 3-5pm	Medicare-Medicaid Beneficiary Listening Group – Coos Bay
Dec. 19, 2011, 1-4 pm	Medicare-Medicaid / Long Term Care Integration Sub-Group
Dec. 20, 2011, all day	Legislature: Interim Joint Health Care Committee hearing
Dec. 20, 2011 9 am-noon	Tribal Consultation
Jan. 10, 2012, 10 am-12 pm	Tribal Consultation
Jan. 10, 2012, 8:30 am-3 pm	Oregon Health Policy Board meeting; public comment accepted
Jan. 18, 2012, 8-11 am	Legislature: House Health Care Committee hearing
Jan. 20, 2012, 1-3 pm	Legislature: Senate Health Care and Human Services Committee hearing
Jan. 24, 2012, 8 am-noon	Oregon Health Policy Board meeting; public comment accepted
Jan. 25, 2012, 10 am-12 pm	Tribal Consultation
Jan. 25, 2012, 9-11 am	Medicaid Advisory Committee
Feb. 2, 2012, 1:30-4:00 pm	FQHC/RHC/IHS & Tribal 638 meeting
Feb. 12, 2012, 9:30 am–2:30 pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 14, 2012, 1-4 pm	Oregon Health Policy Board meeting, public comment accepted
Feb. 14, 2012	Senate passes Senate Bill 1580 by a vote of 18-12
Feb. 16, 2012, 2-3 pm	Tribal Consultation
Feb. 23, 2012	House passes Senate Bill 1580 by a vote of 53-7

Appendix F: Global Budget (selected program areas relevant for Medicare/Medicaid integration)

Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			August 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Physical health care	OHP physical health coverage for individuals enrolled in managed care and FFS (includes emergency transport)	Currently paid through capitation for individuals in managed care.	X			
Mental Health	OHP mental health coverage for individuals enrolled in managed care and FFS	Currently paid through capitation for individuals in managed care.	X			
Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities) for those dually eligible	Basis of payment currently depends on whether or not a beneficiary is enrolled in a Medicare Advantage plan, Medicaid physical health managed care plan.	X			
Addictions	OHP addiction health coverage for individuals enrolled in managed care and FFS	Currently paid through capitation for individuals in managed care.	X			
Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Currently paid FFS.		X		

Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			August 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Mental Health	Exceptional Needs Care Coordinators	Specialized case management service provided to individuals identified as aged, blind or disabled who have complex medical needs. Currently paid through capitation.	X			
Mental Health	Adult residential alcohol and drug treatment (OHP carve out)	HB 3650 states that OHA shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.	Optional	Optional until July 1, 2013		
Transportation	Non-Emergent Medical Transportation	Not currently in capitated rates, but inclusion necessary for coordination and access to care. Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation.		X		
Mental Health	Adult Residential Mental Health Services	High-cost, low-frequency services linked to management of census at state hospitals. CCOs will need to manage utilization and develop alternative services such as access to housing with necessary supports for independent living.		X		
Targeted Case Management	HIV/AIDS Targeted Case Management	Overall services supported by Medicaid and CDC block grant funds.		X		
Dental	OHP dental coverage	HB 3650 states that dental care organizations may choose to operate until 7/1/14 or opt to become part of a CCO sooner.	Optional	Optional	Optional Until July 1, 2014	

Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			August 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Mental Health	Personal Care 20 Client Employed Provider	Providers are individuals selected by service recipient who require minimal ADL assistance (no more than 20 hours per month); Small volume makes inclusion initially in GB difficult.			X	
Mental Health	Community adult outpatient MH treatment services, case management, vocational and social services, locating housing, peer delivered services	A mix of county, Medicaid, general fund, and federal block grant funding.			X	
Mental Health	Mental health support services including supported employment, community geriatric psych specialists, preadmission screening/resident review (PASRR), housing renovations, homelessness supports, housing development	County funding that is a mix of Medicaid, general fund, and federal block grant. Difficult to put into GB initially due to this complexity.			X	
Long Term Care	Long term care institutional and community supports	Specifically excluded from CCO global budgets by statute				X
Mental Health	OHP-covered mental health drugs	Specifically excluded from CCO global budgets by statute				X
Other	Hospital Leverages: DSH, GME, Pro-Share, and UMG					X

Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			August 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Other	FQHC Full-Cost Settlements					X
Developmental Disabilities	Developmental Disabilities Comprehensive Waiver & Model Waivers (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.				X
Developmental Disabilities	Developmental Disabilities Self-Directed Support Services Waiver Only (Targeted Case Management)	Program provides assessments, care plans, referrals and related activities specific to the developmentally disabled population, which CCOs may not have the experience to manage at this time.				X
Mental Health	State Hospital Care - Forensic					X
Mental Health	State Hospital Care - Civil, Neuropsychiatric and Geriatric populations					X
Mental Health	Supervision services for persons under the jurisdiction of the Psychiatric Security Review Board (PSRB)	These are monitoring and reporting functions done by the community mental health programs on behalf of the PSRB and are paid monthly by AMH to the counties.				X
Other	A & B Hospital Facilities Settlements					X
Targeted Case Management	Tribal Targeted Case Management	Program is managed by tribes. State statute prohibits mandatory enrollment of tribal members into CCOs.				X

Appendix G: Shared Accountability for Long Term Care

Strategic Framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care
[Version presented to the Oregon Health Policy Board, Feb. 14, 2012]

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[18].

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), Patient-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-funded 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

[18] For full document including appendix – see the following link:
http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf

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
- 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: 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

Shared Accountability High Leverage Area	Sample or Illustrative Process/Structure Measures	Sample or Illustrative Outcome Measures
Integrated Behavioral Health and Substance Abuse Treatment	% LTC members with positive screening for mental illness or substance use disorder engaged in treatment 30 days from screening date	Rate of emergency department use for individuals with serious mental illness or substance use disorders
Transitions of care for **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 measures[19], 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:

- Relating a portion of overall CCO quality incentive payments 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.

[19] 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.

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.

For full document including appendix – see the following link:
http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf

Appendix H: Memorandum of Understanding Guidance Summary

Summary of OHA/DHS Guidance for Shared Accountability for Long Term Care (LTC) –Memorandum of Understanding (MOU), April 2012

The full guidance can be found: http://www.oregon.gov/DHS/hst/apd-cco-info.shtml, and includes:

- OHA/DHS Guidance Document
- Appendix A: Designated MOU contacts
- Appendix B: APD/AAA service delivery system map
- Appendix C: Overview of the APD/AAA service delivery system
- Appendix D: Sample MOU template
- Appendix E: Glossary of terms

Summary:
The guidance outlines specific expectations for CCOs and LTC offices related to five domains required to be addressed in the resulting MOU, as well as the process and timeline for review/approval of MOUs, and expectations around monitoring and evaluation. In addition, the guidance provides information around eight optional domains for consideration for MOUs. The minimum domains that must be addressed in the LTC/CCO MOU are:

1. Prioritization of high needs members
2. Development of individualized care plans
3. Transitional care practices
4. Member engagement and preferences
5. Establishing member care teams

Additional, voluntary, domains that are relevant to alignment and coordination are suggested in the guidance, but are not required to be included in the MOU. They are:

A. Use of best practices
B. Use of health information technology
C. Member access and provider responsibilities
D. Outcome and quality measures
E. Governance structure
F. Learning collaboratives
G. Role of primary care home
H. Safeguards for members

The guidance builds off the Coordinated Care Organization (CCO) criteria requirements of HB 3650 and is described in the CCO implementation proposal and in the OHA proposal for Medicare/Medicaid Alignment Demonstration. The information in the guidance is specific to the MOU requirement relating to the shared accountability for LTC.

The guidance covers MOUs between CCOs and:

- Type B Area Agency on Aging (AAA)
- State of Oregon Aging and People with Disabilities (APD)

The guidance does not cover:

- MOUs or contracts that CCOs are required to have with local mental health authorities, community mental health programs, community developmental disability programs or support service brokerages. More information will be provided on these topics in the near future.
- The three-way contract required for the Medicare/Medicaid Alignment demonstration between the Center for Medicaid Services (CMS), the State, and the CCO.
- MOUs or contracts that CCOs may choose to enter into in order to provide transformational services envisioned beyond the expectations outlined in this document.

The guidance is intended to provide direction and technical support for the completion of an MOU with an emphasis on local flexibility, innovation and reasonable time frames for initial and ongoing improvements.

DHS/OHA Review/Approval Process:
DHS/OHA will review MOUs to ensure that each of the five required domains is sufficiently addressed. In addition, DHS/APD central office will sign all MOUs with APD LTC local offices, and will countersign MOUs with Type B AAAs.

Time Line* - CCO/LTC MOU

Mid-April – MOU guidance posted online as final
April – Areas with CCO applicants are identified via their Letters of Intent. Local CCO-AAA/APD Offices begin process of MOU development internally with technical assistance from DHS/OHA.
April/May – CCO and AAA/APD offices define process for completing MOU and meet as needed to complete process.
June 15 –MOUs due to APD/OHA for review.
June 30 – APD/OHA review completed.
July 1 – MOU finalized (or by the time the CCO contract is signed)
Aug 1 - MOU operational (or by the time CCOs' contracts are effective)
Ongoing- Monitoring and evaluation

*MOU operational dates listed are for the initial CCO application wave, and will be adjusted for later rolling CCO application waves.

Monitoring and Evaluation
OHA and DHS are developing processes and metrics to support the shared accountability framework discussed above. Within the MOU, the CCO and the LTC office are asked to describe how they will hold each other mutually accountable for agreed upon activities. Listed below are four mechanisms that CCOs and LTC offices may find useful to assure mutual accountability. These mechanisms could be phased in over time, and CCOs/LTC offices may want to update their MOUs to coordinate with the metrics and processes under development by OHA and DHS.

1. Review and assess whether MOU agreements have been carried out, identify strengths of the MOU, challenges or barriers to meeting MOU agreements, unexpected opportunities, informal/anecdotal outcomes, and revise MOU to adjust for this new information;
2. Identify relevant process and/or outcomes metrics related to specific CCO/LTC office joint efforts or goals;
3. Monitor processes: track the extent to which CCOs and LTC offices are interacting around the five required domains (e.g., for how many/what % of CCO members in LTC did AAA provide risk assessments; how many joint care conferences were attended; etc.); and

4. Measure outcomes for the CCO members in LTC to assess whether coordination and joint efforts are having actual impacts on individuals served by both systems with a focus on health equity.

In addition to building mutual accountability into the MOU, DHS/OHA intends to monitor MOUs in a number of ways:

1. CCO metrics developed and monitored by OHA in conjunction with DHS, including analysis of each metric by members receiving Medicaid-funded LTC (see Appendix D of this document);
2. LTC system metrics developed and monitored by DHS in conjunction with OHA (under development);
3. Troubleshooting, informal check-ins with DHS/OHA; and
4. Post implementation evaluation to assess how shared accountability is working, whether MOUs are useful, and what structures and relationships have developed including identify challenges, barriers, best practices, lessons learned.

Appendix I: Index of Letters of Support

The following individuals submitted letters of support for this proposal. These letters are included in a separate document, posted at https://cco.health.oregon.gov/Pages/Medicare-Medicaid-Proposal.aspx.

- Governor John Kitzhaber, MD
- Bruce Goldberg, MD, Director, Oregon Health Authority (OHA)
- Erinn Kelley-Seil, Director, Oregon Department of Human Services (DHS)
- Eric Parsons, Chair, Oregon Health Policy Board (OHPB)
- Carole Romm, Jim Russell, Co-Chairs, Medicaid Advisory Committee (MAC)
- Robin Moody, Director of Public Policy, Oregon Associations of Hospitals and Health Systems (OAHHS)
- Craig Hostetler, Director, Oregon Primary Care Association (OPCA)
- Ruth Gulyas, Executive Director, LeadingAge Oregon
- David H. Fuks, Chief Executive Officer, Cedar Sinai Park
- Ellen Garcia, Executive Director, Providence ElderPlace
- Robert D. Law, MD, Family Physician
- Veronica Sheffield, Transition Care Team / UM Supervisor, WVP Health Authority
- Bob Joondeph, Executive Director, Disability Rights Oregon