State of Oregon
Oregon Health Authority

Proposal to the Centers for Medicare and Medicaid Services

State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

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A. Executive Summary

Since 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 of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;
2. Promote the Triple Aim of better health, better health care, and lower per capita 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 the 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 been a leader among states in providing Medicaid 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 prevention and primary care and addressing the assessed needs of the CCO's particular community. CCOs are community-based organizations governed by a partnership among providers of care, community members and those taking financial risk. A CCO will have a single 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 (through this demonstration). 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 long terms care 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.

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With these reforms, Oregon will be well-positioned to provide better care to those currently enrolled and improved access for those who will become Medicaid eligible 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, 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 2013)
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 beneficiary listening groups (June/Dec. 2011) • Meetings with individual stakeholder groups (ongoing) • More than 60 board meetings, workgroups, Medicaid Advisory Committee meetings, public input to the Oregon Health Policy Board to develop overarching CCO Implementation Proposal (2011-Jan. 2012)
Proposed Implementation Date(s)	January 2013

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 nursing home care for those needing long term supports and services;
- comparatively low hospitalization rates; and

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- 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, Oregon is a national leader; in recent rankings,[3] 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 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/health home) initiative; more than 120 clinics have applied for recognition and 80 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 beneficiaries 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

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[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] 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 (accessed March 2, 2012)

$1.8 billion in combined Medicare and Medicaid annual spending.[4] 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;
- 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 account ability for cost and outcomes; and
- Shared accountability for LTC.

<u>Integration and coordination:</u> 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 "siloed" entity is paid separately by the state or CMS and manages its isolated aspect of an individual's overall health. The current payment system provides little incentive 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.

[4] 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.

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 typically face barriers to care that 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 entity.

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 LTC system. 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.[5] 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.

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. Global budgets will include services that are currently provided under

[5] 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.

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 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 CCOs 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 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 CCOs and the Medicaid-funded long-term care 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. Section C provides a description of the stakeholder-vetted approach to ensuring shared accountability.

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).[6] This will include individuals eligible due to disability, blindness or age, who may or may not receive long term care 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 2013, Oregon estimates there will be an estimated 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.

[6] In 2010, the average monthly caseload for PACE among individuals who are dually eligible was 816. 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; see section on proposed integrated care pilots at the end of Section C.

Oregon has excelled in providing eligible individuals the ability to chose the most appropriate LTC setting and provider to meet their needs. A broad selection of long-term 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 individuals' independence and relationships, both of which can contribute to an individual's overall health. The table below shows the LTC status and care setting for the target populations and subcategories based on senior citizen status. Overall, 37% of the target population 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%.[7]

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. In addition, roughly 10% or 6,000 dually eligible individuals have a 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+
Individuals with serious mental illness[8] (SMI)	(under development)	(under development)	(under development)	(under development)	(under development)

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.
Notes: Table includes individuals with six months of eligibility for Medicare and Medicaid.

[7] 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. The prevalence of institutional and community-based long-term care exclude individuals with mixed institutional and community-based long-term care.

[8] Oregon is refining its analysis of this sub-population and will publish an updated table in the final proposal to CMS.

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. 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 the Medicare and Medicaid benefit to some extent. Nationally, only 15% of individuals who are dually eligible are enrolled in Medicare Advantage plans.[9]

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 Oregon would expect to see delivered 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, 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
- Continuity of care

[9] 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). National statistics Include only enrollees in HIO and MCO plans 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).

- 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 we will be expecting the CCOs to put in place. (See Appendix A for more information about PCPCH standards/structure.) More than 120 clinics have applied and 80 have already been recognized as Patient Centered Primary Care Homes to date. 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 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.[10] Currently, this Medicaid coverage pays members' premiums and all copays on OHP-covered services (items above the funding line on Oregon's Prioritized List of Health Services,[11] 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; Oregon plans to require CCOs to use the statewide evidence-based preferred drug list (PDL) as their Part D formulary for this demonstration starting in 2014, and will seek CMS pre-approval of the PDL as meeting Part D requirements. Appendix E also outlines the alignment of services in Medicaid and Medicare for dually eligible individuals. In addition, CCOs will be expected to provide health promotion and preventive services such as including smoking cessation programs, weight watchers® (or similar), 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. Needs for these services would be individually determined by the CCO in

[10] 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."

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

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 Global Budget funds to cover such when appropriate. 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
- Peer-delivered services
- Educational services, both group and individual
- Culturally-specific or traditional health practices or services as appropriate
- Certain care by paraprofessionals/alternative care providers
- Home or site visits, particularly in coordination with mental health, community, and other public health services

Behavioral health services

Outpatient 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 and their delivery system network are expected to coordinate integrated outpatient mental health and chemical dependency treatment services[12] for members with related health services, including those provided by Medicaid-funded LTC providers and agencies as well as other health services not funded by the CCO when relevant, such as crisis services or other critical safety net services provided by the Local Mental Health Authority or the Community Mental Health Program This includes 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.

Excluded services

Certain services will be provided outside CCOs, either for the short term or permanently. Dental services will continue to be provided by separate Dental Care Organizations (DCOs) through 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 continue to be provided externally until CCO capacity to deliver these services has been developed; these services include residential treatment for mental health and addictions and other services provided by Local Mental Health Authorities. Oregon's authorizing legislation, House Bill 3650 (2011) explicitly excludes Medicaid payment of mental health drugs (continuing the exclusion of these classes 7 & 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 the CCO. Medicaid waiver services to individuals with developmental disabilities and model waivers for children will also

[12] Integrated outpatient 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.

continue to be paid directly by the state. CCOs will be expected to effectively coordinate care for their members across the entire continuum of services, including those services that are excluded.

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 score card ranking from the SCAN foundation, Oregon's Medicaid-funded LTC system is ranked third in the nation.[13] Key highlights from this report include; high rankings for support of families and care givers (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.[14] OHA, along with stakeholders, has sought to maximize the strengths of Oregon's LTC system and the promise of improved coordination through Health System Transformation and adoption of the CCO model.

Despite the successes in LTC delivery, Oregon has parallel health care delivery and LTC delivery systems, which can lead to fragmented care for beneficiaries. Without coordination and alignment between the two systems, some services are duplicated, while others are denied in one system because they don't meet its criteria, even if the service would improve outcomes or reduce costs in the other system. The maintenance of two separate systems without the proposed shared accountability interventions would create the potential for misaligned incentives, poor outcomes for beneficiaries, and higher costs in both systems. Examples of the types of inefficiencies that may occur include:

- Unnecessary emergency room visits and hospitalization due to inadequate care planning;
- Premature entry into LTC after deterioration in condition due to lack of access to behavioral health, durable medical equipment, or other needed services;
- Overuse of mental health drugs and increased acute care costs due to lack of system capacity to care for individuals with mental/behavioral health needs in the LTC system;
- Failure of LTC placement in home and community based setting due to poor hospital discharge planning and poor post-acute care coordination.

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 result in increased costs for CCOs, including costs from avoidable hospitalizations and emergency room utilization, they will have a substantial financial stake in improved coordination; they will also have the financial and information exchange resources needed to facilitate it.

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.

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[13] 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. (accessed March2, 2011)

[14] 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)

- 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, models such as these need to be brought to scale and supported by mechanisms to share accountability. 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 or contract 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: information sharing and coordination of services for high needs members, protocols for linking CCO plans of care with those generated by the LTC system, how the CCO will develop a team approach while including relevant members of the Medicaid-funded LTC system as well as how they will coordinate transitional care. 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.

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 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 side. 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. Local AAAs may create contracts with the CCO to supplement or enhance the activities described in the MOU.

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Metrics: Oregon is working 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, while the full set of outcome measures are being developed. See Appendix D for a full list of the proposed 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 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.

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 negotiation with, and requirements of, CMS related to Oregon's participation in the CMS Financial Alignment Demonstration. There are several options for holding CCOs financially accountable:

- Making a portion of overall CCO quality incentive payments be related to metrics for shared accountability with LTC.
- For LTC providers and AAAs/APD offices, financial incentives tied to performance metrics, depending on availability of funding.
- Shared savings arrangements between CCOs and LTC partners (providers and AAAs/APD offices) 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 quality payments to shared accountability.

As with performance 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.

<u>Impact of CCOs and successful coordination</u>: These shared accountability mechanisms will facilitate further improvements to 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 LTC services who would 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.

See Appendix G for additional information about Oregon's shared accountability strategic framework.

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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 exceptions due to impact on co-morbid conditions. It should be noted that the 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 statewide PDL 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 approach, 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 located along the I-5 corridor, where CCOs are expected to first emerge, 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 primary care home model continues to grow, the Oregon 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 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 above, since the PCPCH program launched in October, more than120 clinics have applied, and 80 have already been recognized as PCPCHs.
- *Non-traditional Health Workers*: A subcommittee of the 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. Approximately 75% reported

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working along the I-5 corridor, the area where we expect the earliest inclusion of individuals dually eligible in CCOs.

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. However, implementation may be phased corresponding with the establishment of CCOs across the state. OHA will collect notices of intent from prospective CCOs through April 2, 2012, and support the establishment of CCOs on an ongoing basis. Thus, information will soon become available on the likely geographic service area of the demonstration at its outset, and the service area is expected to expand during the demonstration.

OHA proposes to enroll beneficiaries in the demonstration using passive enrollment with an option to opt-out, following the CMS-required beneficiary notification process and timelines. Passive enrollment will follow the Medicare-required timeline for both the Medicaid and Medicare benefits. To preserve continuity of care, OHA will consider the dually eligible individuals' current Medicaid and Medicare plan enrollment in determining CCO enrollment. New dually eligible individuals will be enrolled in CCOs with the option to opt-out.

Beneficiaries will continue to have the right to change their Medicare plan throughout the plan year. Beneficiaries that wish to be enrolled in a CCO for Medicare and Medicaid benefits will be required to get their Part D benefits through the CCO; any choice of a separate Part D plan will remove the beneficiary from the CCO for Medicare. Individuals who opt-out of CCOs for Medicare will be considered to have also opted out of the CCO for their Medicaid coverage.

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 and behavioral 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 the aged and physically disabled are excluded from the CCO global budgets as are services under Oregon's five other home and community based 1915 (c) waivers for support services for people with developmental disabilities, behavioral supports for people with developmental disabilities, comprehensive developmental disability services, medically fragile children, hospital model waiver; CCOs are still responsible for the health care needs for individuals receiving these services.

Existing managed LTC programs: Oregon does not currently have any managed LTC programs.

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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 individuals dually eligible 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. It is likely that existing MHOs will either become part of new CCOs or become subcontractors of CCOs. CCOs are expected to provide the full range of mental health services provided by MHOs including inpatient, outpatient, case management, supported employment, supported housing, peer delivered services, and psychiatric residential treatment services for children and adolescents.

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), and most 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, and many 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 participants will not be passively enrolled in CCOs. In addition, as part of this demonstration (see integrated care pilots section below), Oregon is requesting a waiver of certain PACE requirements to allow the expansion of this integrated care model.

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.

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. The state is negotiating a state plan amendment with CMS to provide enhanced reimbursement to PCPCHs for serving qualified OHP members under the Medicaid Health Home option (ACA 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.

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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 Preventative 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 emerging CCOs 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 a waiver to the federal PACE regulations (42 CFR 460) to create a fully integrated care model, allowable under HB 3650, for individuals in LTC who are dually eligible for Medicare and Medicaid. Oregon's waiver specifically requests:

- Elimination of the PACE center requirement;
- Expanded eligibility to include dually eligible individuals of any age who meet state Medicaid eligibility for LTC;
- Aligning CCO consumer protections with PACE;
- Redefining interdisciplinary team membership to match client needs identified in annual assessments;
- State authority to set credentialing and qualifications for interdisciplinary team members.

With approved flexibilities, Oregon envisions creating, "mobile PACE" and "pathway to PACE" programs to encourage expansion and greater access to this program. In addition, Oregon is requesting funding to support implementation elements of these new PACE models, such as technical assistance to new PACE programs, staffing a provider liaison and other start-up administrative costs, as well as "mobile PACE" and "pathway to PACE" evaluations.

Congregate Housing with Services: Oregon is proposing a program to test Congregate Housing with Services 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 Medicare-Medicaid recipients, 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. Pilots would be

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required to partner and coordinate with CCOs for behavioral supports, substance abuse treatment, primary care, and CCO models such as onsite nurse practitioners and wellness programs.

As part of Health System Transformation, Oregon plans to test and evaluate this new 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 long-term care, creation of a culture of wellness, and lower LTC/health costs, and achieve better health outcomes within typically disenfranchised populations. On this last point, 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.

Oregon specifically requests funding for planning and implementation costs including: staff/contractor resources to participate in community and individual needs assessment; technology needs assessment and infrastructure; program planning, design, and development efforts; program/resident educational material design and development; data collection reporting; program evaluation (pre and post), including quarterly reporting and preparation of a final report.

D. Stakeholder Engagement and Beneficiary Protections

Stakeholder engagement to date

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 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 ("Work Group"); (3) OHA's Health System Transformation Community Meetings ("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 ("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. See Appendix A for 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 and 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 were 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's 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.

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. Other outreach that has been discussed includes additional community meetings and beneficiary focus groups. OHA realizes that the transition to the CCO model of care and implementation of the Design proposal will require input from and education of all affected stakeholders.

OHA's Publications and Design Section translates materials to languages other 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.

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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 coordinated access to person-centered care via a primary care team, preferably in a PCPCH setting.

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. OHA's expectation is that care will be coordinated by the CCO for individuals that have had little if any coordination under their current fee-for-service (FFS) Medicare and Medicaid benefits. 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.

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. CCOs will be required to participate in the three-way contracts, contingent on OHA and CMS reaching mutually agreeable terms, after OHA consultation with Oregon's health plans.

As discussed below in Section G, the demonstration is intended to be statewide, but not all areas of the state will have a CCO in place in time to enroll duals on January 1, 2013. OHA intends to bring other areas into the demonstration as CCOs form, and are seeking CMS permission to have organizations enter the demonstration after January 1, 2013.

Payments to plans and providers

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.

Initially, 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 reflect the fundamental care coordination and management activities CCOs are expected to perform. 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.

Certain Medicaid services currently purchased on a fee-for-service basis may instead be purchased through CCOs separately from the blended capitation rate while other services may continue to be purchased outside of CCOs on a temporary basis. These services will ultimately be included into the blended capitated rate, but may be paid for on a different basis initially due to limited historical data, complex financing structures and concerns for continuity of care. 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.

After the first year of CCO operation, a financial incentive structure will be incorporated in the 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 financial incentives for CCOs specifically related to this demonstration beginning in the first year of the demonstration, including a payment withhold related to meeting quality standards and performance targets for care for individuals dually eligible for Medicare and Medicaid. As part of the financial incentives, CCOs will be held accountable for metrics related to shared accountability with the LTC system, as described in Section C above.

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 link payment to 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 will be 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.

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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 a preliminary list of access, member experience, quality, and health or outcome measures that CCOs will be responsible for. This preliminary list includes measures focused on or reported separately for individuals receiving LTC services to ensure CCOs coordinate with and share accountability with LTC systems. In addition, Oregon will work with CMS to identify 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 by June 2012 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 year 1, CCOs accountability will be for an initial set of process measures related to shared accountability for LTC, and otherwise CCOs will be accountable for reporting data. In years 2 and 3, 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;

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- 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

The 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

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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 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 develop a new licensing category for CCOs, and upon certification CCOs will be eligible to negotiate a contract with OHA for Medicaid and with OHA and CMS for dually eligible beneficiaries beginning January 1, 2013. The Insurance Division will also have responsibility for receiving 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.

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.

Demonstration-specific staff will also be required, including, but not limited to, a project director to oversee the demonstration implementation and program analysts to manage implementation; engage, assist and collaborate with new CCOs; and manage the alignment of incentives among the CCOs and LTC providers. Demonstration-dedicated analysts from the DHS Aged and Persons with Disability program will lead implementation activities related to LTC providers and local offices, and will participate in the overall demonstration implementation to assure 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 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 All Payer All Claims, health insurance coverage, hospital and ambulatory discharge, hospital financials, health care acquired infections, and health care workforce to evaluate

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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.

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:

- Network adequacy requirements;
- Enrollment requirements, particularly around timing;
- Part D formulary and other requirements;
- 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.

OHA also looks forward to working with CMS to determine if any waiver of rules is needed in any of these areas.

Plans to expand to other service areas

Oregon expects the demonstration to serve the majority of individuals dually eligible from the start of the demonstration, but acknowledges that some areas of the state may not have an operational CCO in place when the proposed demonstration is scheduled to begin. In this case, Oregon intends to gradually include areas of the state into the proposed demonstration as CCOs form and enter in to the necessary agreements with OHA and CMS.

Overall implementation strategy and anticipated timeline

To the extent possible, implementation of the demonstration will be aligned with 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

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- 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 workplan and timeline.

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% of primary care physicians refused to take new Medicare beneficiaries, in large part due to low rates.[15] While there are additional savings to be found through this model, this 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 does not directly align with the CMS procurement process. OHA's Request for Applications (RFA) will be released in March, before OHA and CMS have completed an MOU process that will be necessary to lay out all expectations plans will need to meet to be certified for three-way contracts with blended Medicare and Medicaid rates. Initial CCO applicants will thus be responding to OHA's RFA in spring, and will be required to respond to additional criteria in summer. Further, CCO applicants will need to submit Part D formularies, benefit packages, and medication therapy management programs to CMS before having complete information on criteria and terms, such as rates, for the three-way contracts. Plans have expressed significant concerns about the impact that applying for the demonstration will have on their current Medicare Advantage and Special Needs Plans bids. To address these challenges, OHA is working closely with CMS to ensure that OHA's RFA includes as many of the demonstration requirements as will be known at the time of the RFA release. Further, OHA will work to communicate information in an expedited manner to CCO applicants and new CCOs about criteria and contract terms for the demonstration.

Balancing these barriers are many forces in our favor: executive level support of this model of health reform, dedicated state staff, and the fact that this proposal fits within a larger effort to reform health care across the state.

[15] 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)

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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 will 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 will officially begin the CCO procurement process by posting the RFA on March 19, 2012. (A draft RFA was posted for public comment, along with draft temporary rules and model contract on March 5.) The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements to the extent they are known. The request for applications will 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 on a rolling basis for a limited time. After applications are received, OHA will review and award certification to eligible CCOs. Certified CCOs will be eligible for negotiated contracts. As noted previously, the alignment of the RFA procurement process with the CMS/OHA joint procurement process for participation in the demonstration will require some flexibility as to timelines.

In support of the core 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 is working with CMS to obtain new Medicaid funding for previously unmatched state programs, under the federal Designated State Health Programs effort. This funding 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
    - Workforce/provider training
    - Change management
    - Marketing and outreach - targeted and broad outreach to members and providers including regular stakeholder meetings
    - Technical assistance to plans - helping plans build capacity to take Medicare, glide path to become CCOs
- 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
- Health analytics and accountability (data, metrics, actuarial analytics)
- Program implementation/operations
- 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. See Appendix H for full budget details.

J. Additional Documentation (as applicable)

See Appendices for additional documentation and resources. Oregon will provide additional information to CMS upon request.

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. To help people heal without complication, CCOs must develop a transitional care approach that uses established or best practices approaches to transitional care management. As a cornerstone in CCO design, PCPCHs will provide organized team based care that provides a structure through which up-to-date, accurate member information is shared and relevant follow-up services are provided when a member transitions between levels of care or across providers of care. Keeping people from getting sicker is in alignment with Oregon's goals, and accountability, quality assurance and quality improvement structures developed for CCOs include key outcomes associated with successful hospital based care, including a measure specifically targeting healthcare acquired conditions. CCO learning collaboratives, once implemented, are expected to include sharing knowledge and best practices related to improvements in 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 strategies 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 needs 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. 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 and service delivery. 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 located in settings that are accessible to families, diverse communities, and underserved populations and to utilize community health workers, personal health navigators and qualified health interpreters in providing culturally appropriate and 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.

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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

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

Input from individuals dually eligible 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

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/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp

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- CMS State Demonstrations to Integrate Care for Dual Eligible Individuals – Design Contracts website: https://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp

Appendix B: Workplan/Timeline

To be included in final version for submission to CMS

Appendix C: List of Acronyms

AAA	Area Agency on Aging
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)
LTC	Long Term Care
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

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

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	**Transformational Measures**	
1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) *Domain(s):Member experience & activation* *Data type: Survey (collected by OHA)* *Also part of:* Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others 2. Rate of tobacco use among CCO enrollees*^ *Domain(s): Prevention, outpatient physical, overall health status, cost control* *Data type: Survey* *Also part of: Nat'l Quality Strategy* 3. Access – Outpatient and ED utilization per member-month*^ *Domain(s):Access, community engagement* *Data type: Claims/encounter* *Also part of: CHIPRA Core, NCQA HEDIS* 4. BMI assessment & follow-up plan*^ / Weight assessment and counseling for children and adolescents *Domain(s): Prevention, outpatient physical* *Data type: Medical record* *Also part of: Medicare ACOs, OR PCPCH, CHIPRA* 5. Screening for clinical depression and follow-up plan^ *Domain(s):Mental health* *Data type: medical record* *Also part of: Adult Medicaid Core, Medicare ACOs* 6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^	1. Rate of early childhood caries *Domain(s):Oral health* *Data type: Medical record* *Also part of: HP 2020* 2. Wrap-around care for children – **TBD** (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) *Domain(s):Care coordination, mental health* *Data type: TBD* *Also part of: TBD* 3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method *Domain(s):Women's health, prevention* *Data type: Survey* *Also part of:* 4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) *Domain(s):End-of-life care, care coordination* *Data type: Administrative or medical record* *Also part of: Pending* 5. Health and functional status – (1) % members who report the same or better mental and physical health status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status *Domain(s): overall health outcomes* *Data type: Survey*	CMS 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 CHIPRA Core Measures including: · Childhood & adolescent immunizations · Developmental screening · 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

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CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	**Transformational Measures**	
Domain(s):Addictions *Data type: medical record* *Also part of: OR PCPCH* 7. Initiation & engagement in of alcohol and drug treatment^ *Domain(s):Addictions* *Data type: Claims/encounter* *Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH* 8. Low birth weight <u>or</u> adequacy of prenatal care *Domain(s):Overall health status, MCH* *Data type: Claims/encounter* *Also part of: CHIPRA* 9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD*^ *Domain(s): Outpatient physical, prevention, cost control* *Data type: Encounter/hospital discharge* *Also part of: Adult Medicaid Core, Medicare ACOs* 10. Healthcare-acquired conditions – TBD *Domain(s):Inpatient care* *Data type: Clinical* *Also part of: CDC and OR HAI reporting, Medicare value-based purchasing, CHIPRA* 11. Follow-up after hospitalization^ - % of members with follow-up visit within 7 days after hospitalization for mental illness *Domain(s):Care coordination* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core*	*Also part of: Medicare ACOs, MA star ratings(1), SNP(2)* 6. ED visits – Potentially avoidable or other categorization TBD (*^) *Domain(s):Outpatient physical, care coordination, cost control* *Data type: Claims/encounter* *Also part of: TBD* 7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members *Domain(s):Access, coordination and integration* *Data type: Survey* *Also part of: Unknown* 8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment *Domain(s):Equity, cost control, potentially others* *Data type: mixed* *Also part of: Unknown* 9. Community Orientation - TBD *Domain(s):TBD* *Data type: TBD* *Also part of: TBD* 10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours *Domain(s):Care coordination* *Data type: Attestation*	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

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CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	**Transformational Measures**	
12. Readmission rates: (1) Plan all-cause readmissions*^; (2) readmissions to psychiatric care^ *Domain(s):Care coordination, cost control* *Data type: Claims/encounter* *Also part of: Adult Medicaid Core, Medicare ACOs* 13. High needs care coordination – TBD (e.g. % of members identified as high need assigned to intensive care coordination) *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 14. Medication management –TBD *Domain(s):Care coordination* *Data type: TBD* *Also part of: TBD* 15. MLR - % of global budget spent on health care and services *Domain(s):Efficiency, cost control* *Data type: Administrative* *Also part of: Unknown*	*Also part of: Adult Medicaid Core*	
CCO-LTC System Joint Accountability Measures		
1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place. *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Pending*	1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day *Domain(s):Care coordination* *Data type: Administrative* *Also part of: Unknown*	

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Appendix E: Covered Benefits as of June 2011

Covered Service	OHP Plus <21 or pregnant & BCCM	OHP Plus >=21 nonpregnant	Individuals Dually Eligibles (not partial)	OHP Standard
Premium	*None*	*None*	*None (Medicare Part B premium paid by Medicaid)*	$9-20 by income; $0 for Am. Indian/ Alaska Native/IHS and <10% FPL
Eligibility category	*Mandatory population*	*Mandatory population*	*Mandatory population*	*Expansion population*
Preventive services				
Immunizations (per ACIP)	X	X	X	X
Preventive medical services--Per HSC lines 3 and 4	X	$3 Copay*	X	X
Preventive dental care for children/adults[1]	X	$3 Copay*	X	X
General Health Services (subject to funding line)				
Acupuncture[2]	X	$3 Copay* (covered for Chem. Dependency only)	X	X (for Chem. Dependency only)
Chemical Dependency and Methadone (Outpatient)	X	$3 Copay*	X	X
Chiropractic[3]	X	$3 Copay*	X	X
Dental Services[4]	X	$3 copay, limited[5]	Limited[5] unless <21 or pregnant	Limited[5]

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Covered Service	OHP Plus <21 or pregnant & BCCM	OHP Plus >=21 nonpregnant	Individuals Dually Eligibles (not partial)	OHP Standard
Family planning & related services†[16]	X	X	X	X
Hospital ER Care (emergency)	X	X	X	X
Hospital Inpatient/OP Care (urgent/emergency)	X	X	X	X
Hospital Inpatient/OP Care (non urgent)	X	X	X	X
Hearing aids/ hearing aid exams	X	X	X	
Labor and delivery	X	X	X	X
Medical Equipment and supplies	X	X	X	Limited[6]
Medical Transportation--Ambulance, emergency (defined by DMAP/Medicare)	X	X	X	X
Mental Health Outpatient[7]	X	$3 Copay*	X	X
Mental Health Hospitalization	X	X	X	X
Naturopathy[8]	X	$3 Copay*	X	
Occupational therapy[9]	X	$3 Copay*	X	
Physical therapy[9]	X	$3 Copay*	X	
Physician Care (Primary)	X	$3 Copay*	X	X
Physician Care (Specialty)	MCOs may require referral	MCOs may require referral; $3 Copay*	No copay; Some plans may require referrals[18]	MCOs may require referral
Podiatry[10]	X	$3 Copay*	X	X
Prenatal care	X	$3 Copay*	X	X
Speech Therapy[9]	X	$3 Copay*	X	
Vision Care--routine[17]	X		Only if <21 or pregnant	

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Covered Service	OHP Plus <21 or pregnant & BCCM	OHP Plus >=21 nonpregnant	Individuals Dually Eligibles (not partial)	OHP Standard
General health services not covered by OHP (below funding line or excluded)	Subject to comorbidity rule	Subject to comorbidity rule	If covered by Medicare and comorbidity rule does not apply, patient responsible for Medicare cost sharing.	Subject to comorbidity rule
Diagnostic Services				
Lab/X-ray (Subject to OHP/Medicare guidelines)	X	X	X	X
Diagnostic evaluations, assessment and screening by medical or mental health providers	X	X	X	X
Hospice and Palliative care				
Hospice Care	X	X	X	X
Other Palliative Care	X	X	X	X
Ancillary Services				
Home health	X	X	X	
Non-emergency transport	X	X	X	
Skilled Nursing Home Care[11]	X (days 0-20)	X (days 0-20)	X (days 0-100)	X (days 0-20)
Private Duty Nursing[12]	X	X	X	
Prescription drugs				
Prescription drugs--Physical	X	$0-$3 Copay* at pharmacy, no copay by mail	X	X

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Covered Service	OHP Plus <21 or pregnant & BCCM	OHP Plus >=21 nonpregnant	Individuals Dually Eligibles (not partial)	OHP Standard
Prescription drugs--MHCD	X	$0-$3 Copay* at pharmacy, no copay by mail	X	X
Prescription drugs--Family Planning[16]	X	X	X	X
Personal Care and Residential Care Services				
MH (AMH)† personal care for adults	X	X	X	X
MH (AMH)† rehabilitative svcs high need(HK)	X	X	X	X
MH Respite care	MCO only	MCO only	MCO only	MCO only
Residential Chemical dependency	X	X	X	X
Other MH (AMH) Services† ● adult and youth resid A/D ● young adults in transition resid ● other community adult OP svcs like vocational and social svcs for housing supports, etc	X	X	X	X
Care Coordination and Case Management[13]				
24-hour nurse advice line	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option
Maternity Case Management†	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option
Disease or Case Management Program	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option	FFS; At MCO's Option
Primary Care Management services (PCM)	FFS Only	FFS Only	FFS Only	FFS Only
Exceptional Needs Care Coordinator (ENCC)	X	X	X	X

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Covered Service	OHP Plus <21 or pregnant & BCCM	OHP Plus >=21 nonpregnant	Individuals Dually Eligibles (not partial)	OHP Standard
Other services and supplies necessary to improve health and/or control costs				
Interpreter Services[15]	X	X	X	X
Lactation consultant services	MCO Only (at MCO option)	MCO Only (at MCO option)	MCO Only (at MCO option)	MCO Only (at MCO option)
Peer-delivered Services (e.g. Living well, AMH peer services)	MCO Only (at MCO option)	MCO Only (at MCO option)	MCO Only (at MCO option)	MCO Only (at MCO option)
Mental health-related Assertive Community Treatment†	FFS only	FFS only	FFS only	FFS only
MH Supportive Employment†	FFS only	FFS only	FFS only	FFS only
Early Assistive (EASA) psychosis program***†	Some counties	Some counties	Some counties	Some counties
Smoking cessation programs	X	X	X	X
Weight watchers (or similar)				
Other misc. services and supplies (e.g. air conditioners, smart pill boxes)				
Other traditional/cultural health practices				
Care by other paraprofessionals ●Community health workers ●Doulas[14] ●Patient navigators				
Individual and group health literacy/education services				

* $3 Copays apply only to ambulatory visits; 1 copay per visit, regardless of services provided

**Placeholder for services like air conditioners for CHF patients, smart pill boxes, vacuum cleaners for asthmatics, etc.

†Services which are done outside of OHP but which are part of Medicaid.

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[1] Preventive dental services include prophylaxis, fluoride, nutritional counseling, sealants, space maintainers and oral evaluation

[2] As of 5/23/2011, acupuncture only appears above the line for treatment of HIV and chemical dependency

[3] Chiropractic services are paired with various above-the-line conditions, including migraine headaches and rheumatoid arthritis. The line for back pain without neurologic involvement, however, appears in the unfunded region of the List as of 5/23/2011

[4] As of 5/23/2011 many dental services appear below the funding line: advanced periodontics, retreatment of root canals for posterior teeth, elective restorative procedures, bridges, orthodontics, implants, cosmetic and minimally-effective treatments

[5] For OHP standard members and OHP Plus members who are not under 21 or pregnant, certain advanced restorative services are not covered (crowns, dentures, etc.)

[6] For OHP standard, medical equipment is limited to diabetic supplies, respiratory & oxygen equip., ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies only.

[7] Evaluations and consultations, therapy, case mgmt, med. mgmt, emergency svcs, partial hospitalization (subacute care), programs to help with daily and community living.

[8] Services that would be covered if an medical doctor performed them, and which are within a naturopath's scope of practice

[9] Rehabilitative services are subject to visit limits and other restrictions

[10] Most services provided by podiatrists are below the funding line as of 5/23/2011

[11] Includes post-hospital extended care

[12] Criteria for private duty nursing are very strict, and this service is seldom approved

[13] Targeted Case Management benefits are not dealt with in this chart. Whether they are included in CCOs will be determined elsewhere.

[14] For the purposes of this chart, doulas are treated as community health workers.

[15] Interpreter Services include services by spoken language interpreters and certified American Sign Language (ASL) interpreters.

[16] The family planning benefits noted in this document pertain only to those provided through OHP/DMAP. Oregon's Public Health Division administers two other family planning programs: Oregon Contraceptive Care (CCare), which is a family planning Medicaid waiver; and Title X, which is a federal public health family planning grant from the Office of Population Affairs.

[17] Routine vision care includes routine eye exams and eyeglasses. Other eye conditions are covered per the Prioritized List.

[18] Some Medicare Advantage and some Medicaid MCOs require referrals. Medicare and Medicaid Fee for service do not.

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

Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Physical health care	OHP physical health coverage for clients enrolled in managed care and FFS (includes emergency transport)	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X			
Mental Health	OHP mental health coverage for clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X			
Dual Eligible Specific	Payment of Medicare cost sharing (not including skilled nursing facilities) and Medicare Advantage premiums 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 clients enrolled in managed care and FFS	Currently paid through capitation; clients receiving coverage FFS would be moved into CCOs as well.	X			
Dual Eligible Specific	Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Cost sharing for Medicare eligibles also eligible for a full Medicaid benefit and enrolled in a CCO will be included in blended capitation rates under CMS demonstration.	X			

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Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Mental Health	Exceptional Needs Care Coordinators	Specialized case management service provided to clients identified as aged, blind or disabled who have complex medical needs. Currently paid through capitation	X			
Physical health care	OHP Post Hospital Extended Care (for non-Medicare eligibles)	Currently in the capitation rate for those in managed care for the first 20 days of care.	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		

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Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
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	
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

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Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Other	Hospital Leverages: DSH, GME, Pro-Share, and UMG					X
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

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Program Area	Program / Service / Function	Notes	Timeline for Inclusion in Global Budgets			
			July 1, 2012	Jan. 1, 2013	Jan. 1, 2014	Not currently planned
Targeted Case Management	Tribal Targeted Case Management	Program is managed by tribes. State statute prohibits mandatory enrollment of tribal members into CCOs.				X

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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

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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.

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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 LTC providers, Licensing and Quality Assurance, LTC Ombudsman. Eligibility and enrollment for Medicaid, Medicaid low-income co-pay.
- Post Acute Skilled Care and Transitions to Medicaid-funded LTC: (see below)
- Medicaid-funded LTC Benefits: In-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, Home Delivered Meals, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages), PACE state plan (including Medicare benefits).
- Other AAA/APD Supports and Services: As the Aging and Disability Resource Connection the following are provided: information and assistance, options counseling; care transitions coaching; nursing facility transition/diversion; connection to evidence based chronic disease

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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

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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
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	% transitions where information transfer occurred same day (e.g.	Rate of emergency department use following transfer

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Shared Accountability High Leverage Area	Sample or Illustrative Process/Structure Measures	Sample or Illustrative Outcome Measures
LTC-Acute **Acute-Post Acute** **Acute-LTC** **Post-Acute - LTC**	nurse to nurse consult or receipt of physician's discharge	
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[16], 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:

- Making a portion of overall CCO quality incentive payments be related to metrics for shared accountability with LTC. Depending on available funding, OHA plans to offer incentives to reinforce these reporting and performance expectations, with the specific incentive design to be determined. CCOs who did not meet performance expectations related to shared accountability for LTC could be at risk for this payment.
- For LTC providers and AAAs/APD offices, financial incentives tied to performance metrics, depending on availability of funding. The development of these metrics would consider which metrics and incentives are appropriate for AAA/APD offices as well as different types and sizes of providers.
- Shared savings arrangement between CCOs and LTC partners (providers and AAAs/APD offices) around benchmarks such as reduced rehospitalization rates and ED utilization (and/or other

[16] 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.

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]

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Appendix H: Budget Request

To be included in final version for submission to CMS

Appendix I: Letters of Support

To be included in final version for submission to CMS

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