2023 Guidance Document on Medicare Plan to CCO Affiliation:

Core Areas to be Addressed in CCO to MA Plan Affiliation Agreements:

This document is not meant to be an Affiliation Agreement template. This document summarizes key provisions in the CCO Contract related to MA relationship and creation of integrated care and processes for FBDE individuals. This may not be an exhaustive list of items the CCO includes in the affiliation agreement or contract. It is a guide as to areas the CCO is responsible for ensuring in its MA relationships for FBDE members.

DSNP Coordination of Benefits Agreements contain additional requirements to coordinate and report on annual performance and CCOs with DSNPs as affiliated plan should be aware of these requirements, specifically items where the CCO needs to work closely with the DSNP to meet expectations. [For same-parent company CCO- DSNPs the COBA takes the place of annual affiliation agreements.]

For Definitions: CCO contract definitions provides detail on many acronyms and abbreviations standardly used. Please refer to these definitions and connected references.

A. Areas for Alignment with CCO Contract

Exhibit B -Statement of Work Part 2: Covered and Non-Covered Services

1. Covered Services: (i) Contractor is responsible for Covered Services for Full Benefit Dual Eligibles for Medicare and Medicaid. Contractor shall pay for Covered Services for Members who are Full Benefit Dual Eligibles in accordance with applicable contractual requirements that include CMS and OHA.

2. Provision of Covered Service: MA agreement should ensure affiliated plan understands expectations for CCOs to ensure provision of covered services in this section. In particular, to ensure FBDE members receive care that meets expectations in sections (a) (b) (c) (e) (g)

3. Authorization or Denial of Covered Service: As applicable to ensure FBDE members receive member materials and authorization that ensures access to needed care and services (a) (b) (c) and that service authorizations are provided within timeframes by creating review with Medicare plan in a timely way.

Ensure where member has right to self-refer to services without prior authorization that those are clear across Medicaid-Medicare delivery system.

For Members with Special Health Care Needs or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care Monitoring, Contractor shall have a mechanism in place to allow Members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports, are authorized in a manner that reflects the member's ongoing need for such services and supports and do not create a burden to

Members needing medications or services to appropriately care for chronic conditions; (reference OAR 410-141-3835)

5. Covered Services: NEMT –ensure processes for meeting access requirements and verifying Medicare appointments and services for FBDE members use of NEMT to access those services s noted under (d) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) with CCO NEMT Broker/Contracted provider(s)

Ensure members know NEMT is available to Medicare-primary appointments. (suggested via member handbook and NEMT rider guide as mechanisms that minimally should call out to dual eligibles access is not just to Medicaid providers/services.)

6. Covered Services: Preventive Care, Family Planning, Et al

Ensure clarify on authorization processes and communication to ensure FBDE members can access the full-scope of preventive care, family planning and other OHP services by adopting shared protocols for authorization, and claims processing.

7. Covered Services: Medication Management as noted in a and b

8. Covered Services Process to access CCO (a) Intensive Care Coordination (b) (c) (d) and other services through CCO outlined in item 9 or 10.

Ensure as noted in a.1(a) ICC: Without requiring a referral, automatically assess all Members of Prioritized Populations for ICC services. Specific to ICC prioritized population as defined in OAR 410-141-3870 Intensive Care Coordination. [Use data fields in 834 to assist in identifying populations]

Ensure clear referral processes to ICC for MA affiliated care team and that any referral from DHS LTSS/LTSS partners is tracked for response. (g) Respond to requests for Intensive Care Coordination assessment services with an initial response by the next Business Day following the request.

As in (i) and (j) ensure members and members representatives have direct method to contact ICC assigned care coordination.

Ensure to specify processes to ensure telehealth access per OHA regulations for telehealth services for OHA covered benefits to FBDE:

e. Telehealth Services: Contractor shall ensure that Telehealth services meet all applicable requirements of OAR 410-141- 3566, including requirements relating to Telehealth reimbursement, service delivery, patient choice and consent, access to care, and compliance with federal and state privacy and confidentiality rules.

MA Affiliation agreements should outline process to ensure access to Medicaid services noted in CCO Exhibit B –Statement of Work –Part 2 --Non- Covered Services including carved out behavioral health and long- term services and supports which are benefits FBDE members must be able to access as medically necessary and appropriate.
https://www.oregon.gov/oha/HSD/OHP/Documents/2022-CCO-Contract-Template.pdf

Ensure care coordination to (9) Non-Covered Health Services with Care Coordination especially carved out behavioral health and LTSS services.

Process to access ILOS where beneficial to member's health 11 (1) The settings or services listed are determined by OHA to be a Medically Appropriate and Cost Effective substitute for a Covered Service consistent with provisions in OAR 410-141-3820.

Exhibit B – Statement of Work – Part 3: Patient Rights, Responsibilities, Engagement, Choice

1. Member and Member Representative Engagement in Member Health care and Treatment plans

Agreement should include any expectations and processes to ensure member/member representative involvement in care planning and the process by which to access items in (a) – (g) specific to CCO to MA relationship

2. Member rights under Medicaid:

Agreement should include clarity on documentation CCO requires of MA plan regarding any items (a) – (t) deemed appropriate in CCO to MA relationship

Furnish required information within 30 days of enrollment notification from OHA and k(1) In instances where Contractor's Members have obtained an MA or Dual Special Needs Plan through one of Contractor's Affiliates, Contractor may choose to send integrated Medicare and Medicaid materials such as a Medicare/Medicaid summary of benefits and Provider directories.

Ensure access to CCO paid interpreters for FBDE members even when Medicare is primary payer of the health care service the FBDE member is receiving.

4. Informational Materials for Members and Potential Members

Agreement should outline expectations for development of integrated materials for FBDE members and processes to coordinate communication as noted in (b)

Process by which written notices to members for material changes are made.

Requirements to ensure disability and language access to member materials per OHA standards and CMS 1557

4b. Contractor shall, at least once every Contract Year, provide FBDE Members with written communications regarding opportunities to align Contractor's benefits with its Affiliated MA or Dual Special Needs Plans, or both as may be applicable. Contractor shall also communicate regularly with Providers serving FBDE Members about such Member's unique care coordination needs and other health care needs, such as ICC Services.

4c. Contractor shall identify opportunities to streamline communications to the FBDE Members to improve coordination of Medicare and Medicaid benefits. Such streamlined communications may include the use of integrated Member materials where possible (such as Member handbooks, Provider directories, integrated ID card formats) as permitted by CMS under Medicare regulations

Accessibility of member materials clarified in this section.

5. Informational Materials for Members and Potential Members: Member Handbook –integrated materials

Integrated materials to be updated (iii) within the time period required by Medicare if the Contractor is providing an Integrated Medicare-Medicaid Member Handbook for the FBDE Enrolled Member is a Fully Dual Eligible Member with their affiliated or contracted MA or DSNP.

6. Informational Materials for Members and Potential members: Provider Directory –integrated materials

See notes on allowable integrated materials and contact us or CMS with any questions

Enrollment:

h. Contractor shall actively support Full Benefit Dual Eligible (FBDE) Member enrollment decisions by providing information about opportunities to align and coordinate Medicaid benefits with Contractor's Affiliated or Contracted Medicare Advantage or Dual Special Needs Plan. This includes ensuring newly Medicare eligible members receive information about the affiliated Medicare Advantage or Dual Special Needs Plan at least sixty (60) days prior to the Medicare effective date.

Marketing to Potential Members:

f With regard to Full Benefit Dual Eligible Members:

(1) Pursuant to OAR 410-141-3575, Contractor may streamline communications to FBDE Members to improve coordination of benefits including development of integrated Member materials (e.g., handbooks, provider directories, summary of Medicare-Medicaid benefits), subject to OHA and CMS Medicare Advantage review and approval.

(2) Contractor may conduct outreach to, or communicate with, FBDE Members in order to notify them of opportunities to align MCE-provided benefits with Medicare Advantage or Dual Special Needs Plans, as described in OAR 410-141-3575 and OAR 410-141-3580.

Exhibit B -Statement of Work Part 4: Providers and Delivery System

Section 1: Integration and Care Coordination

Contractor shall demonstrate participation in activities supporting Continuum of Care that integrates health services by means of, without limitation: et al

b. Contractor shall demonstrate participation in activities supporting the continuum of care that integrates health services by means of, without limitation:

(1) Facilitating enhanced communication and coordination between and among:

(a) Contractor and Oral Health care Providers, and Behavioral Health Providers;

(b) Contractor and MA and Dual Special Needs Plans and Medicare Providers for FBDE Members;

(c) DHS Area Agency on Aging/Aging and People with Disabilities Offices or Office of Developmental Disability Services case managers, and Providers who provide services to Members receiving Long Term Care or Home and Community Based Services and Members with developmental disabilities

who receive services through Community developmental disability programs and organizations.

(2) Educating Members about the Coordinated Care approach being used in the Community, including the approach to addressing Behavioral Health care and be provided with any assistance needed regarding how to navigate Contractor's coordinated care system.

(3) Implementing integrated Prevention, Early Intervention, and wellness activities.

(4) Developing and implementing infrastructure and support for sharing information, coordinating care, and Monitoring results;

(5) Using screening tools and treatment standards and guidelines that support integration;

(6) Supporting a shared culture of integration across CCOs and service delivery systems; and

c. Coordinate to reduce duplication as required by §438.208 (b) (2) and (5)

Section 2: Access to Care

As noted in 2(a)(b)(c)(d)(e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (p) Coordinate linkages with MA Plan to ensure FBDE members are provided access to OHP services in accordance with contractual standards and

Ensure services and supports provided in cultural and linguistically appropriate Culturally and detail on expectations on requirements for compliance with requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act I (h), (i), (j), (k)

2a (5) For Members with Special Health Care Needs or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care Monitoring, Contractor shall have a mechanism in place to allow Members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports, are authorized in a manner that reflects the member's ongoing need for such services and supports and do not create a burden to Members needing medications or services to appropriately care for chronic conditions;

(l) Contractor shall ensure that each Member has an ongoing source of primary care appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3860 and required by 42 CFR 438.208 (b)(1) and (2).

Specific to Integrated Treatment/Care Plans and Transition Plans

Access to Care Item 2(g) Expectations for those with special health care needs or LTSS, including assessment in order to identify any ongoing special conditions that require a course of physical health, Behavioral Health services, or care management, or all or any combination thereof and detail on requirements for ICCPs.

Section 2(6) Contractor shall have policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, CCO or MA or DSNP Plan Care Coordinators, and DHS case managers where appropriate, an integrated treatment or care plan, or transition of care plan for Members:

(a) With Special Health Care Needs,

(b) Receiving Long Term Services and Supports, including those Members currently receiving either Medicaid–funded Long Term Care or Long Term Services and Supports from DHS,

(c) Who are transitioning from Hospital or Skilled Nursing Facility care,

(d) Who are transitioning from institutional or in-patient Behavioral Health care,

(e) Who are receiving Home and Community Based Services for Behavioral Health conditions, and

(f) FBDE Members enrolled in Contractor's Affiliated MA or DSN Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.

Specific Coordination with Affiliated MA plans

Section 2. p. To effectively integrate and coordinate health care and care management for FBDE Members, Contractor shall demonstrate its ability to integrate and provide Medicare and Medicaid benefits to FBDE Members through direct affiliation or contract with one or more MA Plans that serve FBDE Members throughout the entirety of Contractor's Service Area. This shall include, at a minimum, policies and procedures that promote and employ:

(1) An integrated approach to ensuring FBDE Members have a PCPCH or PCP,

(2) Integrated care plan development,

(3) Coordination of care transitions to reduce readmissions,

(4) Collaboration to ensure and Monitor Member access to preventive screenings and tests and Behavioral Health services, [DSNPs have required reporting to OHA around behavioral health that requires collaborative data collection with CCO].

(5) Coordination of care management services for those requiring ICC services;

(6) Coordination of NEMT services to Medicare and Medicaid Covered Services;

(7) Work to coordinate HIT to enhance use of HIE, EHR and event notifications as provided for in Ex. J of this Contract; [DSNPs have required reporting that requires collaborative data collection with CCO]

(8) Integrated communications and Member materials as permitted under Medicare; and [DSNPs required to use Integrated Denial Notice for FBDE members]

(9) Use of CMS MA and DSNP Medicare Plan enrollment mechanisms for newly eligible Medicare members. {for non-DSNP or DSNP without CMS approved Default Enrollment process, this would refer to CMS Simplified Enrollment Mechanisms }

Section 3: Delivery System and Provider Capacity –Provider Network and Enrollment a (1) (2) (3) (4) (5) (6) (7) b.

Section 5 and 6: Credentialing and PCPCH

Ensure credentialing and provider process complies with requirements to screen for CMS exclusion; access to provider credentialing documentation if required; process to enroll for Medicaid crossover billing including notifying of non-enrolled Medicare providers on how to enroll to receive cross-over payment for QMBs

Discuss opportunities to promote PCPCH model across Medicare and Medicaid affiliated plans. Patient-Centered Primary Care Home: (a) (b) (c) (d) (f)(1)

As per contract section, Coordinate MA services for FBDE members with Behavioral health service providers; addictions/treatment and residential; Oregon State hospital and other institutions

Section 7. Care Coordination: Processes to ensure OHP FBDE members receive integrated care as set forth in (a) (b) (c) (d) (h); where applicable inclusion across plans in (e) (f)

(b) Contractor shall work with Providers, and for FBDE Members, work with Affiliated MA and Dual Special Needs Plans or Medicare Providers, to develop the partnerships necessary to allow for access to, and coordination with, social and support services, including culturally specific Community-based organizations, Community-Based Behavioral Health services, DHS Medicaid-Funded Long Term Services and Supports providers and case managers, including Home and Community Based Services under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver, DHS Office of Developmental Disability Services, Community-based developmental disability Providers and organizations, and mental health crisis management services;

(g) Contractor shall use Evidence-Based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness, Special Health Care Needs, or other chronic conditions, who receive home and Community-Based services under Section 1915(i), the States Plan Amendment, or any Long Term Services and Supports through DHS as follows:

(1) Assignment of responsibility and accountability: Contractor shall document that each Member has a PCP or primary care team that is responsible for coordination of care and transitions;

(2) Individual care plans: Contractor shall use individualized care plans to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with ICC health needs. Contractor shall ensure that individual care plans developed for Members reflect Member, Family, or caregiver preferences and goals to ensure engagement and satisfaction; and

(3) Communication: Contractor shall encourage and work with their Providers to develop the tools and skills necessary to communicate in a Culturally and Linguistically Appropriate fashion and to integrate the use of HIE and event notification.

8. Care Integration:

Agreement should include processes to ensure OHP FBDE members receive integrated care as set forth in (a)(1) (2) (3) (4) and (b)

9. Delivery System Dependencies and 10. Evidence-Based Clinical Practice Guidelines

Agreement should include processes to ensure members have access to ICC services as noted in (a) Intensive Care Coordination for Prioritized Populations and Members with Special Health Care Needs

and promote communication and coordination as noted in sections (b) (c) (d) with other provider types/settings.

(3) Contractor shall implement procedures to share with Participating Providers, in order to avoid the duplication of services and activities, the results of its identification and Assessment of any Member identified as (i) having Special Health Care Needs, including older adults, (ii) being blind, deaf, hard of hearing, or have other disabilities, (iii) having complex medical health needs, high health care needs, multiple chronic conditions, Behavioral Health issues, including SUD, or (iii) receiving Medicaid-Funded Long Term Services and Supports including Long-Term Care or Home and Community Based Services consistent with 42 CFR § 438.208.

(4) Contractor shall create procedures and share information (e.g. via HIE or regularly scheduled interdisciplinary or multidisciplinary care conferences) for the purposes permitted under ORS 414.607 and subject to the information security and confidentiality requirements set forth therein as well as any other confidentiality and information security requirements of this Contract and other Applicable Laws.

(5) Contractor shall establish a system supported by written policies and procedures, for identifying, assessing and producing a Treatment Plan for each Member identified as having a special healthcare need or receiving LTSS, including a standing Referral process for direct access to specialists. Contractor shall ensure that each Treatment Plan: as outlined in a-d subitems.

Address needs for shared evidence-based clinical guidelines across plans.

11. Subcontractor Requirements: Extent to which CCO will require MA plan to submit documentation of Subcontractors compliance with Medicaid provisions and documentation of federal compliance

This would Inclusion of requirements for MA plan to where applicable under b. require Subcontractors to submit valid claims for services as in (d) and (e),(f), (g) express statements about compliance with Medicaid/CMS rules, audits, specify involvement in grievances and appeals process (11)

New: (4) Contractor shall evaluate and document all prospective Subcontractors' readiness and ability to perform the scope of Work set forth in the applicable Subcontract prior to the effective date of the Subcontract. …If Contractor has a contract with a prospective Subcontractor that involves performance of services on behalf of Contractor for a Medicare Advantage plan operated by Contractor or its parent company or subsidiary, Contractor may satisfy the requirements of this Subpara. (4) by submission of the results of its Subcontractor readiness review evaluation required by Medicare, but only for Work identical to that to be Subcontracted under this Contract and only if the Medicare readiness review has been completed no more than six (6) months prior to the effective date of the prospective Subcontract.

13. Adjustments in Service Area or Enrollment:

Specific provisions in (b) items (1) (2) (3) (4)

Exhibit B -Statement of Work Part 8: Accountability and Transparency of Operations:

1. Record Keeping Requirements, 2. Privacy, Security and Retention of Records, 3. Access to Records

Alignment where MA plan record keeping impacts CCO accountability and reporting for FBDE members

4. Payment procedures

Underline processes to coordinate payment processes as noted in this section CCO contract for FBDE members to not create undue delay in review and notification of coverage determinations or access to OHP services, especially where member's health condition requires timely processing of requests

Ensure procedures to address (e), (f) and (g)

Establish processes for (i)

6. Medicare Payers and Providers

Address processes by which CCO and MA affiliates will work to address issues as noted in this entire section, **especially on how plans will work to process claims, handle Medicare crossovers, etc.**

Including how plan will work with their affiliated or contracted MA or DSNP plan to process authorization requests collaboratively for FBDE members enrolled in both plans to not create undue delay in review and notification of coverage determinations, especially where member's health condition requires timely processing of requests.

Contractor shall have an automated crossover claims process in place for its Affiliated MA and Dual Special Needs Plans. Contractor shall submit to OHA, via Administrative Notice, by February 15, 2022, an Attestation stating that the automated crossover claims process is fully implemented and in effect. Contractor shall submit such Attestation by February 15th of any subsequent Contract Year immediately following a change in Contractor's Affiliated MA and Dual Special Needs Plans.

In accordance with OAR 410-141-3565, when Contractor's Medicare-eligible Members receive Medicare Part A and Part B Covered Services from a Medicare Provider, Contractor shall pay, after adjudication with the applicable Medicare or Medicare Advantage Plan, the Medicare deductibles, coinsurance, and Co-Payments, in accordance with the State's methodology up to Medicare's or Contractor's allowable amounts, applicable to the Part A and Part B Covered Services received. Providers must be enrolled with Oregon Medicaid in order to receive such cost sharing payments. Accordingly, Contractor is obligated to pay such amounts only if the Medicare Provider is enrolled with Oregon Medicaid, and in such event, Contractor is obligated to pay such dual enrolled Provider regardless of whether such Provider is one of Contractor's Participating or Non-Participating.

6.Medicare Payers and Providers

a. Contractor shall be an Affiliate of, or contract with, one or more entities that provide services as a Medicare Advantage plan serving FBDE Members throughout the entirety of Contractor's Service Area. Contractor shall demonstrate on a yearly basis that its Provider Network is adequate to provide both the Medicare and the Medicaid Covered Services to its FBDE Members. Contractor's Affiliated Medicare Advantage Plan or Affiliated Dual Special Needs Plan(s) shall meet the network adequacy standards for such Plans as determined by CMS and set forth in the applicable rules and by utilizing the Section 1876 Cost Plan Network Adequacy Guidance handbook located at the following URL: https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/index.html.

(1) In the event CMS audits Contractor's Affiliated MA Plan or its Affiliated Dual Special Needs Plan (or both of them), Contractor shall provide the results of any such audit to OHA, via Administrative Notice, within ninety (90) days of receipt.

(2) In the event Contractor's Affiliated MA Plan or its Affiliated Dual Special Needs Plan (or both of them) fails to meet network adequacy standards as determined by CMS, Contractor shall:

(a) Provide Members with access to specialty care service Providers in accordance with 42 CFR § 422.112(a)(3), at the Member's in-network cost sharing level for the applicable specialty in Contractor's Service Area; and

(b) In accordance with 42 CFR § 422.112(a)(2), Make other arrangements to ensure access to medically necessary specialty care if Referrals from PCPs are required but Contractor's Provider Network is not adequate to enable its FBDEs to select a PCP.

b. Pursuant to OAR 410-141-3865, Contractor shall coordinate, if Medically Appropriate, with Medicare payers and Providers for the care and benefits of Members who are eligible for both Medicaid and Medicare.

c. Contractor shall, in accordance with 42 CFR § 438.3(t):

(1) Have and maintain a Coordination of Benefits Agreement (COBA) with CMS;

(2) Follow CMS protocols as outlined in CMS guidance materials at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page; and

(3) Coordinate with the CMS national crossover contractor, Benefits Coordination & Recovery Center (BCRC), in order to participate in the automated crossover claims process for FBDE Members in Medicare, including where applicable Medicare Part D Plans and Medigap Plans.

(4) Follow posted file formats and connectivity protocols in CMS guidance materials.

(5) Ensure its Providers are notified of billing processes for crossover claims processing consistent with Para. a above of this Sec. 6, Ex. B, Part 8.

d. Contractor shall have an automated crossover claims process in place for its Affiliated MA and Dual Special Needs Plans. Contractor shall submit to OHA, via Administrative Notice, by February 15, 2022, an Attestation stating that the automated crossover claims process is fully implemented and in effect. Contractor shall submit such Attestation by February 15th of any subsequent Contract Year immediately following a change in Contractor's Affiliated MA and Dual Special Needs Plans.

e. In accordance with OAR 410-141-3565, when Contractor's Medicare-eligible Members receive Medicare Part A and Part B Covered Services from a Medicare Provider, Contractor shall pay, after adjudication with the applicable Medicare or Medicare Advantage Plan, the Medicare deductibles, coinsurance, and Co-Payments, in accordance with the State's methodology up to Medicare's or Contractor's allowable amounts, applicable to the Part A and Part B Covered Services received. Providers must be enrolled with Oregon Medicaid in order to receive such cost sharing payments. Accordingly, Contractor is obligated to pay such amounts only if the Medicare Provider is enrolled with Oregon Medicaid, and in such event, Contractor is obligated to pay such dual enrolled Provider regardless of whether such Provider is one of Contractor's Participating or Non-Participating Providers. Contractor should provide non-enrolled Providers with

information about enrolling with Oregon Medicaid in order to receive the cost sharing payments. Contractor shall require Fee for Service Medicare Providers who provide services to FBDE Members to comply with OAR 410-120-1280(8)(i).

f. In the event Contractor's Medicare-eligible Members are provided with urgent care or emergency services by a Medicare Provider, Contractor shall pay for all such services not covered by Medicare even if (i) the provider is a Medicare provider not enrolled with Medicaid once the provider enrolls with Oregon Medicaid, or (ii) the provider is a Medicare provider enrolled with Oregon Medicaid but is not one of Contractor's Participating Providers.

g. Contractor is not responsible for Medicare deductibles, coinsurance and Co-Payments for Skilled Nursing Facility benefit days twenty-one (21) through one hundred (100).

h. If Contractor is an Affiliate of, or contracts with, an entity that provides services as a Medicare Advantage plan serving FBDE Members, Contractor may not impose cost-sharing requirements on FBDE Members and Qualified Medicare Beneficiaries that would exceed the amounts permitted by OHP if the Member is not enrolled in Contractor's Medicare Advantage plan.

i. Contractor shall provide an annual Report to OHA that identifies its affiliation or contracts with Medicare Advantage Plan entities in Contractor's Service Area(s). Contractor shall provide its Report to OHA, via Administrative Notice, by no later than November 15 of each Contract Year using the Affiliated Medicare Advantage Plan Report template located on the CCO Contract Forms Website. Contractor shall promptly update its Affiliated Medicare Advantage Report prior to November 15 any time there has been a material change in Contractor's operations that would affect adequate capacity and services, and upon OHA's request. Contractor shall also provide all updated affiliation agreements or contracts annually as required as part of the MA affiliation report due November 15 of each Contract Year.

7. Eligibility Verification for FBDE

Agreement should address process to verify FBDE status. Address specifically process by which as in (a) EDI 834-member information for FBDE members in affiliated/contracted MA plan are to receive member information such as any enrollment in LTSS, language or disability services needed, etc. and (b) Contractor will require use of OHA system to verify eligibility or receive timely eligibility through CCO

a. If Contractor is Affiliated with or contracted with a Medicare Advantage plan for FBDEs for Medicare and Medicaid, Contractor shall use 834 Electronic Data Interchange transaction set and 270/271 Health Care Eligibility Benefit Inquiry and Response transaction sets, and share Member information in the EDI 834 Benefit Enrollment and Maintenance files with its Affiliated MA or Dual Special Needs Plans (or both of them as applicable).

b. Contractor shall require its Providers to verify current Member eligibility using the Automated Voice Response system, 270/271 Health Care Eligibility Benefit Inquiry and Response transactions, or the MMIS Web Portal.

Other: Insurances: As deemed appropriate by CCO/MA plans to meet CMS and OHA requirements [also in Exhibit F CCO contract]

Exhibit B -Statement of Work Part 9: Program Integrity

10. Program Integrity: Fraud, Waste and Abuse Plans, Policies and Procedures

Address as deemed appropriate which should include communication about where to report a case of fraud, waste or abuse in Oregon Medicaid.

Agreement should cover extent to which MA plan is required to share any material audit findings around Fraud, Waste and Abuse with CCO.

Exhibit B –Statement of Work Part 10: Transformation, Quality and Performance Metrics

Affiliation agreement should outline any expected involvement in transformation and quality strategy requirements (see specific requirements for DSNPs in sample DSNP COBA Agreement) to address FBDE member health improvement projects or Performance Measurement reporting)

All CCOs required to build annual TQS quality improvement projects that for FBDE members in partnership with affiliated Medicare plan(s) and to incorporate measurable tracking activities such as including both Medicaid and Medicare tracking and outcome activities and metrics. Plans are encouraged to open dialogue to discuss well before TQS plans are due annually. DSNPs required to have a collaborative TQS for FBDE members. Details on requirements in TQS guidance materials.

https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

****DSNP Plans can share expectations for reporting to OHA under their contracts that require cooperative data collection with CCOs around Behavioral Health, Event Notifications, TQS projects; and other items in the 2023 DSNP OHA Coordination of Benefits Agreement. (COBA) ****

Address Exhibit E: Required Federal Terms and Conditions

Address Exhibit I: Processes for Grievances, Appeal:

Affiliation agreement should include expectations around creating seamless service authorization and any plans and processes for use of the CMS Integrated Denial Notice where CMS allows or DSNP COBA requires. [DSNPs required to use IDN for FBDE enrolled in both plans]. Service authorization timelines should aim to reduce FBDE member's overall wait-time to receive service authorization review.

Address Exhibit J: HIT: **DSNPS have reporting requirements in this arena**

Alignment with HIT Roadmap materials to work to ensure Medicare Providers are able to access care coordination information from referrals, real-time notifications, share medical information, build integrated care plans:

(a) proportion of contracted physical, behavioral and oral health Providers who have adopted EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR);

(b) proportion of contracted physical, behavioral and oral health Providers who have access to HIE and proportion

using HIE for Care Coordination; and

(c) proportion of contracted physical, behavioral and oral health Providers who have access to, and proportion using, Hospital Event Notifications (HEN) and Skilled Nursing Facility (SNF) event notifications.

Address Exhibit K: Social Determinants of Health and Equity

CHP related quality improvement, promotion of integrated care, SDOH activities, culturally or linguistically based systems, workforce development or other evidence-based identified across plans for FBDE based on requirement that CHP that must identify strategies that support the CHP health priorities and goals promoting integrated care. Plans will be specific to each CCO's CHP identified strategies.

Exhibit M: Behavioral Health

Affiliation agreement should establish clearly establish processes to ensure timely access to full-scope of OHP covered services and any expectations of CCO for MA plan as outlined in Exhibit M including specific protocols to assist in ensuring integration, transition and collaboration of partners; process for referrals, any prior authorizations and approval processes, as well as screening requirements, linkage to ICC, as outlined in this section.

Please see DSNP COBA sample for specific requirements of Oregon DSNPs for Behavioral Health and Behavioral Health reporting of FBDE members in the DSNP

Additional reference documents related to CCO-LTSS MOU processes which should incorporate the MA plan and Medicare providers https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-LTSS.aspx

TQS Technical Assistance Page and Guidance materials: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

For questions related to material in this document, please contact Jennifer Valentine at Jennifer.B.Valentine@oha.oregon.gov