**Guidance Document on Medicare Plan to CCO Affiliation:**

**Core Areas to be Addressed in CCO to Medicare Advantage 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 Medicare Advantage (MA) relationship and creation of integrated care and processes for Full Benefit Dual Eligible (FBDE) individuals which should be included in the affiliation agreement requirements. This may not be an exhaustive list of items the CCO includes in the affiliation agreement or contract. It is a guide to areas the CCO is responsible for ensuring in its MA relationships for FBDE members.*

*Dual Eligible Special Needs Plan (DSNP) Coordination of Benefits Agreements (COBA) 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.*

*Please refer to CY2025 CCO Contract for full text of each referenced item in this document. This is meant to assist you in development of the annual affiliation agreement. Format follows the sections of the CCO contract that are most relevant, although the list in this document should not be considered exhaustive.*

## A. Areas for Alignment with CCO Contract

***Exhibit B, Part 2: Covered and Non-Covered Services***

Section 1. Covered Services:

Contractor is responsible for Covered Services for Full Benefit Dual Eligibles (FBDE) for Medicare and Medicaid as outlined in this section and throughout the contract. 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. Although Medicare is primary, FBDE members rely on Non-emergency transportation (NEMT) to attend both Medicare and Medicaid appointments, the CCO to provide any Interpreter Services or ensure access for those with disabilities, and to coordinate with the members' Medicare Advantage plan and Medicare providers to ensure those additional Medicaid providers and services never covered by Medicare are accessible to achieve the best outcomes for the FBDE members [CHWs, Peer Services, certain community behavioral health preventive services, any additional vision or oral health services, etc.]

Section 2. Provision of Covered Service:

MA agreement should ensure affiliated plan understands expectations for CCOs to ensure provision of covered services in this section. FBDE members must receive care that meets expectations in paras. (a) (b) (c) (e) (g) (h) and (i).

Section 3. Authorization or Denial of Covered Service:

As applicable in this Section to ensure FBDE members receive member materials, notices and authorization that ensures access to needed care and services as outlined in this section and that service authorizations are provided within timeframes by reviewing with Medicare plan in a timely way so that there is not substantial delay in access to care or covered services.

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

Additional key related reference:

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 [OAR 410-141-3835 11 (c), 42 CFR § 438.208].

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 [42 CFR § 438.210].

Section 4. Covered Service Component: Crisis, Urgent and Emergency Services:

While Medicare will likely cover all urgent and emergency services as primary, affiliation agreements should address plan to complete follow-up these services with integrated care plans to reduce likelihood of avoidable ED visits and unnecessary hospital readmissions. Certain Behavioral Health Crisis services may only be available in Medicaid covered services, so appropriate access should be ensured for FBDE populations via affiliation agreements.

Section 5. Covered Services: Non-Emergent Medical Transportation (NEMT):

Ensure processes within this entire section for meeting NEMT access and service requirements and verifying Medicare appointments for FBDE members use of NEMT. Special attention should be given to members with disabilities or in rural areas who may lack other forms of transport to all types of services and supports. Of particular importance, all scheduling notifications in subsection paras (10) and (11) and access to grievances in subsection g (2) required.

Ensure members and providers know NEMT is available to Medicare-primary appointments and is not limited to Medicaid covered services (suggested inclusion in member handbook and NEMT rider guide and where possible through the affiliated Medicare Advantage plan).

Section 6. Covered Services: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care:

Ensure clarity 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. Ensure information sharing across providers to reduce duplication of services, including any screenings and medical tests.

Section 7. Covered Services: Medication Management

Align with affiliated Medicare Advantage/Part D as noted in subsections paras. (a) and (b).

Section 8. Covered Service Components: Other Services

Para. (a) Care Coordination – Ensure alignment with MA plan for provision of Care Coordination to all members consistent with OARs 410- 141-3860, 410-141-3865, and 410-141-3870 and 42 CFR § 438.208. Ensure maintenance of Care Coordination (CC) policies and procedures that ensure CCO, and affiliated MA plan engage in collaborative Care Coordination for FBDE Members as outlined in other sections of this contract and updated OARs.

- Ensure clear referral processes to care coordination for MA affiliated care team and that any referral to or from ODHS LTSS/other LTSS programs or partners is tracked for response.
- Ensure members and members representatives have direct method to contact assigned care coordination individual or team.

Paras. (b) – (e): Provide members with clear processes for where and how to access any covered services outlined for Tobacco Cessation, Breast and Cervical Cancer treatment, Oral Health Services, and Telehealth Services.

Ensure specific processes to access telehealth for OHA covered benefits by FBDE: 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 Provide clarity with affiliated MA plan to providers on any process differences for telehealth for Medicare covered services vs. OHP covered services for FBDE members.

Section 9. Non-Covered Health Services with Care Coordination:

Ensure care coordination to any carved-out services in this section, especially behavioral health and LTSS services.

Section 10. Non-Covered Health Services without Care Coordination

Same requirements outlined in this section for all OHP members apply to FBDE members. As noted, ensure NEMT is available to members to access these services.

Section 11. In Lieu of Services (ILOS)

Provide equitable access to ILOS services to FBDE duals as plan's other OHP members per guidance materials and detail in this section.

***Exhibit B, Part 3: Patient Rights, Responsibilities, Engagement, Choice***

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

As detailed in this section, CCO and Affiliated MA partner shall actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of Treatment Plans and Member dignity is respected. Contractor shall encourage Members to be responsible and active partners in the primary care team and shall protect Members against underutilization of services and inappropriate denial of services.

Agreement should include any expectations and processes to ensure member/member representative involvement in care planning.

Section 2. Member rights under Medicaid:

Affiliation Agreement should ensure CCO's written policies regarding the Member rights and responsibilities under Medicaid law specified below and in OAR 410-141-3590 are extended to FBDE and include clarity for all items in this section as appropriate in CCO to MA relationship and rights to Medicaid benefits and services. Highlights of this section to be addressed in affiliation agreements include but are not limited to:

- Plans should furnish required information to FBDE in Para. (b) as noted. 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 but must also ensure members receive information on their Medicaid rights. [Para. (c), Para. k, Sub. Para. (1)]
- Ensure clear process for all providers and members to access to CCO paid interpreters for FBDE members even when Medicare is primary payer of the health care service the FBDE member is receiving.
- Requirements for providing information in member's language as spelled out in this section apply to all FBDE.
- Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's plan and develop and provide written

information materials and educational programs consistent with the requirements of OAR 410-141-3580 and 410-141-3585

- Require, and cause its Participating Providers to require, that Members receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language, and ability to understand, including provision of auxiliary aids and services to ensure disability access to health information as required by Section 1557 of the ACA.
- Ensure access to second opinions as outlined.
- Allow each Member the right to: (i) be actively involved in the development of Treatment Plans if Covered Services are to be provided; (ii) participate in decisions regarding such Member's own health care, including the right to refuse treatment; (iii) have the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or Behavioral Health treatment; (iv) execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act; and (v) have Family involved in such Treatment Planning.

Section 4. Informational Materials for Members and Potential Members:

CCO shall assist Members and Potential Members in understanding the requirements and benefits of Contractor's integrated and Coordinated Care Services plan, which should include clarity on how to access Medicaid benefits, such as what is covered by their Medicare plan and how to access the additional Medicaid services [i.e. dental services in OHP may cover more than Medicare]. As outlined in this section, CCO written informational materials and educational programs shall be consistent with the requirements of OAR 410-141-3580, 410-141-3585, and 42 CFR § 438.10 providing general information to Members and Potential Members and where possible aligned with affiliated plan communications to reduce any FBDE member confusion.

Affiliation Agreement should address expectations for development of integrated materials for FBDE members and processes to coordinate communication as noted:

- Para. (b) 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.
- Para. (c) 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.
- Para (d), Sub. Para. (3) Include language in large print (18-point font) clarifying or otherwise advising Members: (a) Auxiliary aids, sign language, and other interpretation services are available to deaf or blind Members, Members who are both deaf and blind,

or Members with other disabilities that require any such service(s) pursuant to Section 1557 of the ACA or the Americans with Disabilities Act (ADA); (b) Information shall be made available, at no cost to the Member, through oral interpretation for all languages and how to access these services, in accordance with 42 CFR § 438.10 (d)(1), and as defined in 42 CFR § 438.10 (c); and (c) How to request and access these alternative formats.

- Para (f) Contractor shall submit all Member notices, informational, educational materials, and Marketing Materials to OHA, via Administrative Notice, for review and approval: (i) prior to use and distribution to Members or any other third parties, unless an exception is granted by OHA in writing; or (ii) by a date certain when so identified in this Contract; and (iii) as may be requested by OHA or its designees from time to time.

Accessibility of member materials clarified in this section.

Additional detail on member or potential member materials for review in development of integrated materials (which may be most applicable to Highly Integrated DSNPs), included in **Section 5** and **Section 6.** See notes on allowable integrated materials [including within DSNP coordination of benefits agreements] and contact us or CMS with any questions.

Section 8. Enrollment:

Para. (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.

Section 13. Marketing to Potential Members:

Para. (f), Sub. Para. (1) and (2) With regard to Full Benefit Dual Eligible Members:

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.

Contractor may conduct outreach to, or communicate with, FBDE Members in order to notify them of opportunities to align CCO-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:

Para. (a) CCOs shall ensure affiliation agreements demonstrate shared participation in activities supporting Continuum of Care that integrates health services by means of, without limitation as

outlined in this section. This includes working to share Health Risk Assessment and other key information across plans to reduce duplication and improve member engagement.

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

> Sub. Para (1) Facilitating enhanced communication and coordination between and among Contractor and Oral Health care Providers, and Behavioral Health Providers; Contractor and MA and Dual Special Needs Plans and Medicare Providers for FBDE Members; ODHS Area Agency on Aging/Aging and People with Disabilities Offices or Office of Developmental Disability Services case managers, and any developmental disability or LTSS service Providers (or both) [such as 1915i services].
>
> Sub. Para. (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.
>
> Sub. Para. (3) Implementing integrated Prevention, Early Intervention, and wellness activities.
>
> Sub. Para. (4) Developing and implementing infrastructure and support for sharing information, coordinating care, and Monitoring results in accordance with OAR 410-141-3860.
>
> Sub. Para. (5) Using screening tools and treatment standards and guidelines that support integration.
>
> Sub. Para. (6) Supporting a shared culture of integration across CCOs and service delivery systems.

This includes coordination with your affiliated MA plan(s) to reduce duplication as required by 42 CFR §438.208 (2).

Section 2: Access to Care

CCO shall provide Culturally and Linguistically Appropriate Services and supports in locations as geographically close as possible to where Members reside or seek services. Contractor shall also provide a choice of Providers (including physical health, Behavioral Health, Providers treating Substance Use Disorders, and Oral Health) who are able to provide Culturally and Linguistically Appropriate Services within the Delivery System Network that are, if available, offered in nontraditional settings that are accessible to Families, diverse Communities, and underserved populations.

Para. (a) CCO shall meet, and require all Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. Contractor shall comply with OAR 410-141-3515 and 410-141-3860. Contractor shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week, when Medically Appropriate.

As noted in Paras. (b) through (w) Coordinate linkages with MA Plan to ensure FBDE members are provided access to all OHP services, especially those not covered by Original Medicare or Medicare Advantage plan as appropriate.

- Affiliation agreement should directly point to roles in creating integrated care plans as specified in this section. Sub. Para. 2 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), in accordance with and subject to 42 CFR § 438.208(c) and as may otherwise be required under this Contract, 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 each such Member's ongoing need for such services and supports and does not create a burden to Members who need medications or services to appropriately care for chronic conditions. Sub Para 3: Contractor shall have policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, 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, (c) Who are transitioning from a Hospital or Skilled Nursing Facility care, (d) Who are transitioning from institutional or in-patient Behavioral Health care facilities, (e) Who are receiving Home and Community Based Services for Behavioral Health conditions, and (f) FBDE Members enrolled in Contractor's Affiliated MA or Dual Special Needs Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.
- Para. (g): CCO shall implement mechanisms to Assess each Member with Special Health Care Needs and Members receiving Long Term Services and Supports 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. The Assessment mechanisms must use appropriate health care professionals. For those Members with Special Health Care needs and Members receiving Long Term Services and Supports who are determined to need a course of treatment or regular care Monitoring, Contractor shall:

  (1) In accordance with OAR 410-141-3865 and 410-141-3870, develop and implement a written Care Coordination Plan, and any and all revisions and updates thereto, for each such Member which must be: (i) developed by the entity designated as primarily responsible for coordinating such Member's services, with Member participation and in consultation with any Providers, Specialists, guardians, and other relevant individuals identified in 410-141-3865 caring for the Member; (ii) approved by CCO in a timely manner; and (iii) revised upon Assessment of function, need, or at the request of the Member. Such Care Plan revisions must be done made in accordance with OARs 410-141-3865 and 410-141-3870 at least every three (3)

months for Members receiving care coordination Services and every twelve (12) months for other Members, if approval is required. All Care Plans must be developed in accordance with any and all applicable OHA quality Assessment and performance improvement and Utilization Review standards;

(2) Assist such Members in gaining direct access to Medically Appropriate care from physical health or Behavioral Health Specialists, or both, for treatment of the Member's condition and identified needs including the assistance available through the entity designated as primarily responsible for coordinating such Member's services Care Coordinators, if appropriate; and

(3) Contractor shall implement procedures to share with such Member's Primary Care Provider the results of its identification and Assessment so that those activities are not duplicated. Contractor's procedures shall also require that the Members' Assessments be shared with other CCOs serving the Members. Such coordination and sharing of information must be conducted in accordance with Applicable Laws governing confidentiality.

- Para. (h): CCO shall ensure FBDE members receive covered services that comply with the requirements of Title III of the Americans with Disabilities Act, and Title VI of the Civil Rights Act, and Section 1557 of the ACA by assuring communication and delivery of Covered Services to Members with diverse cultural and ethnic backgrounds. Contractor shall, in order to ensure the communication about, and delivery of, Covered Services in compliance with such Acts, provide, without limitation:
    - (1) Certified or Qualified Health Care Interpreter services for those Members who have difficulty communicating due to a medical condition, a disability, or have limited English proficiency; or
    - (2) Auxiliary aids and services when no adult is available to communicate in English or Certified or Qualified Health Care Interpreters cannot be made available by telephone.
- Para. (m): In addition to access and Continuity of Care standards specified in the rules cited in Para. a, of this Sec. 2, Ex. B, Part 4, Contractor shall develop a methodology for evaluating access to Covered Services as described in Sec. 1, Ex. G of this Contract and Continuity of Care which are consistent with the Accessibility requirements in OARs 410-141-3515, OAR 410-141-3860, and OAR 410-141-3865, and 410-141-3870
- Para. (n): 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 OARs 410-141-3860, 410-141- 3865, and 410-141-3870 and as required by 42 CFR 438.208 (b)(1) and (2). (1) In accordance with Enrolled Oregon Senate Bill 1529 (2022), Contractor must allow a Member to choose a new PCP at any time
- Para. (r): 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 employ and 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 Setting transitions to reduce readmissions,

(4) Collaboration to ensure and Monitor Member access to preventive screenings and tests and Behavioral Health services,

(5) Care Coordination with affiliated Medicare plans and Medicare Providers as outlined in OARs 410-141-3860, 410-141-3865, and 410-141-3870 (or DSNP Coordination of Benefits Agreements where applicable);

(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;

(8) Integrated communications and Member materials as permitted under Medicare; and

(9) Use of CMS MA and Dual Special Needs Plan enrollment and communication mechanisms for newly eligible Medicare Members.

Section 3. Delivery System and Provider Capacity:

Para. (a) Address specifics related to ensuring provider capacity for FBDE members in Sub Paras. (1) through (8).

Section 4. Provider Selection:

Create alignment with Para. a, Sub. Paras. (1) through (8) where relevant (i.e., around use of Qualified or Certified healthcare interpreters on Oregon registry) for services to FBDE in CCO and Affiliated Plan(s).

Section 5. Credentialing:

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.

Section 6. Patient Centered Primary Care Homes (PCPCH):

Consider Affiliation Agreement opportunities to promote PCPCH model across Medicare and Medicaid affiliated plans in this section on Patient-Centered Primary Care Home as noted in Paras. (a) – (f).

Section 7. Indian Health Care Providers:

Work with affiliated plan(s) to serve FBDE members who wish to receive care from Indian Health Care Providers as specified in Para. (a), Sub. Paras. (1) through (4).

Section 8. Care Coordination:

Affiliation agreements should address cross-plan processes to ensure OHP FBDE members receive integrated care as set forth in this section by providing all of the elements of Care Coordination as set forth in this Sec. 7, Ex. B, Part 4 and in accordance with OARs 410-141-3860, 410-141-3865, and 410-141-3870.

Section 9. Care Integration:

Agreement should include processes to ensure OHP FBDE members receive integrated care as set forth in this section and specifically as noted in Para. a, Sub Para. (4) Engage in collaborative Care Coordination for FBDE Members with Contractor's Affiliated MA or Dual Special Needs Plans, or both as applicable.

Section 10. Delivery System Dependencies:

Align with requirements in this section Para. (a) State and Local Government Agencies and Community Social and Support Services Organizations, Para. (b) Cooperation with Dental Care Providers and Para. (c) Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes since FBDE have increased needs than other Medicare-only populations and CCOs can foster relationships to share resources via Affiliation Agreements.

Section 11. Evidence-Based Clinical Practice Guidelines:

Affiliation agreements should highlight opportunities to promote evidence-based practices as outlined in this section.

Section 12. Subcontract Requirements

Align affiliation agreements with expectations in this section to monitor and ensure contractors are not excluded providers as outlined in Paras. (a) and (b), especially where inclusion of requirements by MA plan to include where applicable express statements about compliance with Medicaid/CMS rules, audits, or specify involvement in grievances and appeals process for FBDE members.

Section 14. Adjustments in Service Area or Enrollment:

Affiliation agreement should align with provisions in this section and specifically call attention to specific detail:

Para. (b), Sub. Paras. (1) through (4) If Contractor experiences a change which may result in the reduction or termination of any portion of Contractor's Service Area or may result in the Disenrollment of a substantial number of Members from Contractor, Contractor shall provide OHA, via Administrative Notice, with written notice of such change and a plan for implementation at least ninety (90) days prior to the date of the implementation of such plan.

(1) If Contractor ceases to be Affiliated with a MA or Dual Special Needs Plan (or both), Contractor shall provide OHA, via Administrative Notice, with notice of such change. Contractor shall also provide a transition of care plan for FBDE Members within one hundred and twenty (120) days prior to termination of the Affiliation.

(2) If Contractor dissolves or otherwise shuts down its Affiliated MA or Dual Special Needs Plan business (or both), or such Plans cease to do business in Contractor's Service Area, Contractor shall provide OHA, via Administrative Notice, with notice of such change. Contractor shall also provide its FBDE Members with notice one hundred and twenty (120) days prior to such change in operations.

(3) In the event of an Affiliated MA or Dual Special Needs Plan (or both) closure or reduction in Service Area, Contractor shall work with the local DHSODHS Area Agency on Aging/Aging and People with Disabilities offices in the area(s) affected to ensure FBDE Members receive choice counseling on alternative Medicare plans.

(4) Contractor shall transition its FBDE Members to their respective new Medicare Plans in a timely manner in accordance with OAR 410-141-3850.

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

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

Affiliation agreements should ensure alignment where MA plan record keeping impacts CCO accountability and required reporting for FBDE members.

Section 4. Payment procedures:

Underline processes to coordinate payment as noted in this section 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 Paras. (e), (f), (g), (h) and (i) in this Section, especially around content regarding inappropriate billing to members are specified.

Section 5. Claims Payment:

Align affiliation agreement language to ensure ability to meet requirements in this section.

Section 6. Medicare Payers and Providers:

Address all parts of this section in affiliation agreements to ensure processes by which CCO and MA affiliates will address issues especially on how plans will work to process claims, handle Medicare crossovers, etc.

Affiliation agreements should address 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.

Para. (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/files/document/medicare-advantage-and-section-1876-cost-plan-networkadequacy-guidance06132022.pdf.

(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.

Para. (b) Pursuant to OARs 410-141-3860, 410-141-3865, and 410-141-3870, 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.

Para. (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-benefits-recovery/coba-tradingpartners/agreement; 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.

Para. (d) Contractor shall have an automated crossover claims process in place for its Affiliated MA and Dual Special Needs Plans. If there has been any change in Contractor's Affiliated MA and Dual Special Needs Plans since the prior Contract Year, Contractor shall submit to OHA, via Administrative Notice, by February 15 of the current Contract Year an Attestation stating that the automated crossover claims process is fully implemented and in effect.

Para. (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).

Para. (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.

Para. (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).

Para. (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.

Para. (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.

Section 7. Eligibility Verification for FBDE:

Affiliation Agreement should address process to verify FBDE status and have methods to ensure EDI 834-member information for FBDE members in affiliated/contracted MA plan are shared [i.e., member information such as any enrollment in LTSS, language or disability services needed, etc.]. CCO shall need to require use of OHA system to verify eligibility or receive timely eligibility through CCO as detailed in this Section as follows:

Para. (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).

Para. (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.

***Exhibit B, Part 9: Program Integrity***

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

Affiliation agreements should ensure that they include requirements in this Section 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, Part 10: Transformation, Quality and Performance Metrics***

Affiliation agreement should outline any expected involvement in transformation and quality strategy requirements to address FBDE member health improvement projects or Performance Measurement reporting.

Section 2. Transformation and Quality Strategy (TQS) Requirements:

Align with this section and with posted guidance materials. CCOs required to submit a FBDE Special Health Care Needs TQS project with their affiliated alignment. DSNPs also have annual reporting for TQS. 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 that require cooperative data collection with CCOs around Behavioral Health, Event Notifications, NEMT, TQS projects; and other items in the DSNP OHA Coordination of Benefits Agreement. (COBA) ****

Section 6. Performance Improvement Projects:

Consider opportunities to conduct Performance Improvement Projects for FBDE with aligned plan(s)that align with this section.

***Exhibit D and Exhibit E***

Address compliance with sections of Exh. D and Exh. E related to required State law and required federal terms and conditions in affiliation agreements.

***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.

***Exhibit J***

Section 1. Health Information Technology Requirements:

a. Contractor shall maintain a Health Information System that: i) meets the requirements of this Contract; ii) meets the requirements of 42 CFR § 438.242 and section 1903(r)(1)(F) of ACA; and iii) collects, analyzes, integrates, and reports data that can provide information as outlined in this Section.

Section 2. Health Information Technology (HIT) Roadmap:

All plans should work to ensure increased use of their HIT roadmap to enhance information sharing and work toward greater use of event notifications for building integrated care and addressing care setting transitions for FBDE population with their affiliated plan(s).

DSNPs have additional required reporting per federal Bipartisan Budget Act rule on tracking use of Skilled Nursing Facility (SNF) Event Notifications and Hospital Event Notifications (HEN) and annual reporting on HIT roadmap improvements in use of HIE such as Certified HER by network providers.

Section 3: Interoperability and Access to Health Information

Ensure plans comply with the amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule (CMS-9115-F), and OAR 410-141-3591 and in this section.

Para. (a) Contractor shall comply with the amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule and OAR 410-141-3591. The provisions of the CMS Interoperability and Patient Access Final Rule, with which Contractor is required to comply are: 42 CFR § 438.242(b)(5)-(6), 42 CFR § 457.1233(d), 42 CFR § 438.62(b)(1)(vi) & (vii). These rules include requirements relating to the: (i) use of application programming interfaces (APIs) to: (y) provide patient access to payer claims, encounter information, and costs, and (z) make managed care plans' Provider directories publicly available; and (ii) exchange of certain patient clinical data between payers.

***Exhibit K: Social Determinants of Health and Equity***

This section includes Community Health Improvement Plan 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.

Agreements should address process to coordinate SDOH resources and support navigation to community resources and partners for FBDE Members across plans as outlined in Exhibit B, Part 2, Sections 15 & 16, Section 10 Health Equity Plans.

Plans should report any alignment for FBDE in their Community Health Improvement Plan activities, detailed expectations outlined for CHPs in Section 7.

***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, Sections (1) and (3) in particular, 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.

**B. Additional Resources**

***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@dhsoha.state.or.us**

### *C.* Annual Affiliation Agreement Due Date

Annual due date for Affiliation agreements is December 1st.

- CY2025 Affiliation agreement due Dec. 1, 2024
- CY2026 Affiliation agreement due Dec. 1, 2025

Please upload via the CCO Deliverables Portal.