|  |
| --- |
| Affiliated Medicare Advantage Plan Report OHA requires Coordinated Care Organization (CCOs) to provide information about their affiliated or contracted Medicare Advantage (MA) Plans. CCOs are expected to have relationships with MA Plans in alignment with their entire CCO Service Area. **Each CCO must complete and submit this annual report by November 28, 2024,** for Medicare plan year 2025. Please work with your CCO’s affiliated MA Plans and/or Dual Eligible Special Needs Plan (DSNP) to complete the report. Please submit this report via the Contract Deliverables portal located at <https://oha-cco.powerappsportals.us/>. The submitter must have an OHA account to access the portal. Contact Jennifer Valentine at [Jennifer.B.Valentine@oha.oregon.gov](mailto:Jennifer.B.Valentine@oha.oregon.gov) with any questions about how to complete it. This report content is subject to public posting and redaction. It will be shared without redaction with the Centers for Medicare and Medicaid Services (CMS) and with the Oregon Department of Human Services.Each CCO must also submit a copy of the updated affiliation agreement or contract with any MA plan that is a CCO’s affiliated or contracted plan, unless the plan is a same-parent company Dual Eligible Special Needs Plan (DSNP) that has a DSNP contract on file with OHA for 2025. The affiliation agreement(s) or contract(s) should be submitted to OHA no later than December 1, 2024.Any CCO that needs to request a DSNP MA Coordination of Benefits Agreement (COBA) for CY 2026 must submit its request to the Contract Deliverables portal by no later than December 10, 2024. Contracting for CY 2026 DSNPs begins in spring 2025. COBAs for CY2026 must be fully executed by late June 2025 to ensure health plans can upload their contracts to CMS by the federal deadline of July 1, 2025.[[1]](#footnote-1) |

A picture containing logo

Description automatically generated

|  |  |
| --- | --- |
| **CCO Name** | **CCO Medicaid Contract #** |
|  |  |
| **CCO Contact for this Report (name and email address)** | **Medicare Plan Year** |
|  | 2025 |

**A. List each affiliated, contracted, or owned MA Plan entity.** As stated in the CCO contract, each CCO shall be an Affiliate of, or contract with, one or more entities that provide services as a Medicare Advantage plan serving Full Benefit Dual Eligible (FBDE) Members throughout the entirety of the CCO’s Service Area.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Legal Name of***  ***MA Plan*** | ***CMS Medicare Plan # / PBP*** | ***CCO Aligned Service Area for MA Plan***  ***(by county; must be in alignment with CCO Service Area)*** | **TYPE OF RELATIONSHIP** | | |
| ***Affiliated*** | ***Contracted*** | ***Owned*** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**B. Please highlight top three strategic goals your CCO and affiliated MA Plan(s) have prioritized to impact care and improvement in outcomes (including CCO metrics) for dual eligible members for 2025.** These can include 1) goals your CCO is prioritizing to work on from Table D; or 2) goals aligned with targeted work that is a focus CCO-wide and includes coordination between the CCO and MA Plan. If your CCO has more than one affiliated MA Plan and different strategic goals with each Plan, please fill out the table below for each affiliation. If the goals are the same across all affiliated Plans, only submit one response under this Section B. NOTE: Dual Special Needs Plans (DSNPs) are subject to any additional requirements and reporting as outlined in the Coordination of Benefits Agreement (COBA) with OHA.

|  |
| --- |
| Priority 1 |
| Priority 2 |
| Priority 3 |

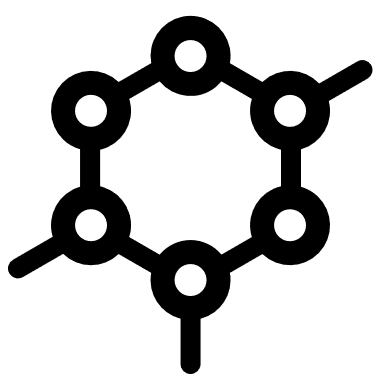
**C. Provide the following information regarding your affiliated, contracted, or owned MA Plan’s premium and the Low-Income Subsidy (LIS) level.** If published CMS premium is over LIS/anticipated to be over LIS for the Medicare plan year for this report, then please provide clarity on whether a strategy is in place to ensure monthly out of pocket costs are uniformly addressed for all members in your CCO and affiliated MA Plan/s. List all plans that are not DSNP plans, even if not over LIS premium level still put plan on grid.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Legal Name of***  ***each MA Plan*** | ***CMS Medicare Plan # / PBP*** | ***CCO Aligned Service Area for each MA Plan***  ***(by county; must be in alignment with CCO Service Area)*** | ***CMS published premium amount over LIS*** | ***Plan’s process to ensure limited out-of-pocket for FBDE duals/detail on any coverage or waiving of Medicare premium\**** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\* OHA may require additional information based on CMS guidance. Please see DSNP Look-Align Information from [CMS Updated Look-Alike Guidance](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CY25_DSNP_LookAlike_Transition_Memo040524_G.pdf) and [CY2025 Medicare Advantage final rule](https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit).

**D. Use the table below to describe the level of Coordination between your CCO and its affiliated or contracted MA Plan(s) for FBDE Members.** If your CCO has more than one affiliated or contracted plan in your Service Area, please complete this table for each plan. For simplicity and clarity, the narrative format used in past years has been replaced with checkboxes. The goal is to ensure OHA has a clear picture of how your CCO’s affiliation is working to build integrated approaches for FBDE Members. NOTE: Coordination with affiliated or contracted MA Plans should, at a minimum, address all CCO contract requirements marked with an asterisk (\*) in the table below (for further reference see the MA Affiliation Guidance document and CCO contract).

The items below are required by the CCO Contract or DSNP COBA agreement, or they are items identified by CMS to showcase the level of integration happening between CCOs and their affiliated MA Plan(s) that OHA is required to document and report to CMS about Oregon’s integrated approach to serving dual eligibles.

**To complete the table:** For each numbered category,check the box for each item in the left column that is currently in place or will be in place in 2025, and then briefly describe in the right column any specific improvements in the category your CCO is working on to improve the integrated approach with your affiliated MA Plan(s) in 2025. Refer to the posted OHA Guidance Document on Medicare Plan to CCO Affiliation and the CCO Contract for more specific detail on each item. Additional DSNP required items are marked by symbol .

| ***Legal Name of Affiliated MA Plan*** |  | ***CMS Medicare Plan # / PBP*** | |  |
| --- | --- | --- | --- | --- |
| ***Type of Coordination (\* = Required in MA Affiliation per CCO Contract)***  ***Select all processes in place as part of your CCO’s Affiliation*** | |  | ***Briefly describe how your CCO & affiliated MA Plan(s) are making improvements in each category to integrate care in 2025*** | |
| **Category 1 - Member and Provider Communication About Coordinated Care Linkages Across Plans** | | | | |
| Integrated Member ID Cards/Medicare ID with OHP Number/OHP Card with Medicare ID  Communication sent to FBDE Members with Medicare Plan Alignment Information at least annually\* [Exh. B, Part 3, Sec. 4, Para. b]  Communication sent to FBDE Member with Medicare Plan Alignment Information 2-4 x per year (quarterly)  Information about availability of NEMT services for Medicare and Medicaid Appts is shared with Providers\* [Exh. B, Part 2, Section 5]  Information about availability of NEMT services for Medicare and Medicaid Appts is shared with FBDE Members\*[Exh. B, Part 2, Section 5; Exh. B, Part 3, Sec. 2 and Sec. 5]  Process to access auxiliary aids and services or interpreters for Medicare and Medicaid Appts shared with Providers \* [Exhibit B, Part 3, Sec. 2; Exhibit B, Part 4, Sec. 2 Access to Care (t), and Sec. 4 Provider Selection (7); Exhibit K Section 10 Health Equity Plans; and Sec. 1557 of the Affordable Care Act (ACA), 42 U.S.C. 18116]  Process to access auxiliary aids and services or interpreters for Medicare and Medicaid Appts shared with FBDE Members\* [Exhibit B, Part 3, Sec. 2; Exh. B, Part 3, Sec. 4 para d (3); and Sec. 1557 of the Affordable Care Act (ACA), 42 U.S.C. 18116]  Process to access care coordination services provided to both Medicare and Medicaid network providers and to members\* [Exh. B, Part 2, Sec 8; OARs 410-141-3860, 410-141-3865, and 410-141-3870; and 42 CFR § 438.208]  Process to access Health-Related Services (HRS) or Social Determinants of Health (SDOH) resources provided to both Medicare and Medicaid network providers and FBDE members\* [Exhibit B, Part 2, Sections 15 & 16; Exhibit K, Section 10 Health Equity Plans]  Integrated provider information in Online Provider Directories (see allowances for integrated directories in guidance; DSNP required to indicate Medicaid provider information in DSNP directory Chemicals with solid fill.) [Allowable per Exh. B, Part 3, Sec. 4, Para. c; Exh. B, Sec 2, para k]  Other integrated communication materials (i.e., member benefits summary, member handbook, etc.) ***Please specify:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Default Enrollment Process in place for newly Medicare eligible CCO members (DSNP only)  Medicare opt-in enrollment process in place for newly Medicare eligible CCO members (active enrollment process)  834 Information sharing process in-place across plans\* | |  |  | |
| **Category 2 - Service Authorizations, Claims Crossover Processing and Member Notices** | | | | |
| Automated Claims Process with Affiliated Medicare Plan(s)\* [Exh. B, Part 8, Section 6 (d)]  Automated Claims Process with simultaneous review of Medicare and Medicaid benefits  Simultaneous Medicare/Medicaid service authorization review/pre-service review  Process in place to coordinate DME requests/reviews for prior authorizations or ongoing authorizations across MA and Medicaid plans [Exh. B, Part 2. Sec. 3; Exh. B, Part 4, Sec. 2]  Process in place to ensure cross-plan review does 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\* [Exh. B, Part 2. Sec. 3; Exh. B, Part 4, Sec. 2 and OAR 410-141-3835]  Affiliated MA plan is using an Integrated Denial Notice with integrated OHP information (required for DSNPsChemicals with solid fill.) instead of or with OHP NOABD for fully aligned FBDE members.  Process to ensure authorizations are provided in both Medicare and Medicaid supporting individuals with ongoing or chronic conditions or those requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports\* [Exh. B, Part 2. Sec. 3; Exh. B, Part 4, Sec. 2; OAR 410-141-3835; and 42 CFR § 438.208]  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; 42 CFR § 438.208]  Ensure Medicare providers are provided information on how to enroll to receive crossover claims processing (including process to enroll for Medicaid crossover billing for non-network Medicare FFS providers) \* [Exh. B, Part 8, Section 6; OAR 410-141-3565]  Ensure all network providers receive information on federal Qualified Medicare Beneficiary (QMB) requirements annually\* [Exh. B, Part 8, Sec. 6; OAR 410-141-3565] | |  |  | |
| **Category 3 - Care Coordination Planning Across Plans** | | | | |
| Event Notifications utilized across plans for care coordination (Skilled Nursing Facility (SNF) and Hospital Event Notifications (HEN))—annual tracking and reporting required for DSNPs per CMS regulationChemicals with solid fill.  Inclusion of MA plan in Interdisciplinary Care Team meetings/care coordination planning, including those for members with Special Health Care Needs or Medicaid-funded LTSS or LTSS-needs\* (see CCO-LTSS MOU materials and reporting <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-LTSS.aspx>) [Exh. B, Part 4, Sec. 2 and Sec. 8]  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 treatment plan, course of physical health, Behavioral Health services, or care management, or all or any combination\* [Exh. B, Part 4, Secs. 2, 7 and 8; and 42 CFR § 438.208]  Process to share member care planning/care plan information across all providers involved in member’s care, develop integrated care or treatment plans, and where possible use real-time event notifications to inform collaborative care planning processes\* [Exh. B, Part 4, Secs. 2, 7 and 8; OAR 410-141-3865]  Process for sharing CCO Health Risk Assessment, MA Health Risk Assessments (HRA), Risk Identification or Stratification Across Plans, and/or LTSS service levels as part of development of comprehensive care or treatment plans\* [Exh. B, Part 4, Sec 1; OAR 410-141-3865]  Process to ensure coordination with MA plan for FBDE members with Behavioral health service providers; addictions/treatment and residential; Oregon State hospital and other institutions, access to Medicaid-only behavioral health services and programs, carved-out medications, Community-based developmental disability Providers and organizations, and mental health crisis management services\* [Exh. B, Part 2, Sec 1 and 8; Exh. M, Sec. 1 and 3; OARs 410-141-3860, 410-141-3865, and 410-141-3870; and 42 CFR § 438.208]  Process to ensure tracking of access to community-based Medicaid BH services and reduction of avoidable ED visits and hospital readmissions in part by reviewing annual BH report data for FBDE members with on-going Behavioral Health Conditions [required for all DSNPsChemicals with solid fill ]  Process to coordinate dental care treatment and access for FBDE members across plans\* [Exh. B, Part 4, Sec. 1 and 10; OAR 410-141-3865]  Process to coordinate SDOH resources and support navigation to community resources and partners for FBDE Members across plans\* [Exhibit B, Part 2, Sections 15 & 16; Exhibit K, Section 10 Health Equity Plans]  Process by which plans coordinate primary care home assignment and access for FBDE members across plans\*[Exh. B, Part 3, Sec. 1; Exh. B, Part 4, Sec.2; Exh. B, Part 8, Sec. 6; and OAR 410-141-3865]  Process in place by which plans ensure meaningful engagement of member/member’s representative in care planning for FBDE members across plans\* [Exh. B, Part 2, Sec 8; OARs 410-141-3860, 410-141-3865, and 410-141-3870; and 42 CFR § 438.208.]  Integrated care coordination ensures the services furnished to FBDE Members from all providers across service delivery systems are complimentary, comprehensive and avoid duplication of services\* [Exh. B, Part 2, Sec 8; OARs 410-  141-3860, 410-141-3865, and 410-141-3870; and 42 CFR § 438.208.] | |  |  | |
| **Category 4 - Care Transitions Planning Across Plans** | | | | |
| Event Notifications Across Plans (SNF and HEN)—annual reporting required for DSNPs\*  Inclusion of MA Plan in interdisciplinary team meetings/care settings transition planning for FBDE members\* [Exh. B, Sec. 2; Exh 4, Sec 1; and OAR 410-141-3870]  Policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan, or care settings transition plan for Members [Exh. B, Part 4, Secs. 2, 7 and 8; OAR 410-141-3870]\*  Evidence-based hospital discharge planning process in place and monitored for completeness. Required of DSNPs.Chemicals with solid fill  Tracking system in place across plans to monitor transitions where discharge orders (DME, medications, transportation, LTSS or in-home care needs assessments) were arranged prior to discharge/did not delay discharge and communication of discharge plans provided to all parties. Required in annual CCO-LTSS report reporting\* and for DSNPsChemicals with solid fill [Exh. B, Part 4, Sec. 8] | |  |  | |
| **Category 5 - Utilization Review and Quality Monitoring** | | | | |
| Monitoring utilization of preventive services, programs and screenings for FBDE members across plans\* [Exh B, Part 3, Sec. 1; Exh. B, Part 4, Sec. 2, Para. r]  When plans identify FBDE member’s underutilization of preventive services, programs and screenings with providers and members, outreach plans are activated to increase utilization. [Exh B, Part 3, Sec. 1; Exh. B, Part 4, Sec. 2, Para. r; Exh B, Part 4, Sec. 8]  Annual Transformation and Quality Strategy (TQS) Special Health Care Needs (SHCN) improvement project to address FBDE members [Exh. B, Part 10, Sec.2]. Required for all DSNPs,Chemicals with solid fill collaborative FBDE project with Affiliated MA plans required for all plans\* per guidance https://www.oregon.gov/oha/hpa/dsi-tc/pages/transformation-quality-strategy-tech-assist.aspx.  Tracking system in place to work collaboratively to monitor NEMT issues for FBDE and create improvement plan as needed—required for DSNP reportingChemicals with solid fill  Quality review process in place to assess cross-plan processes and outcomes and plan improvements annually for FBDE members (i.e. within CCO metrics, PIPs, TQS projects, etc). [Exh. B, Part 10, Sec.2, Sec. 3, and Sec. 6]  Community Health Improvement Plan related quality improvement, promotion of integrated care, SDOH activities, culturally or linguistically based systems, workforce development or other evidence-based innovations identified across plans for FBDE based on completed assessment that per contract must identify strategies that support the integrated care and improved outcomes for all members and the larger community\* [as outlined in Exhibit K, Sec. 7]  Please write in/specify CCO’s identified CHP priorities for FBDE or tell us what documentation was submitted to OHA with FBDE CHP priorities called out (such as increased focus on ensuring interpreters are available for FBDE members appointments with providers).  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  | |
| **Category 6 - Access to Services** | | | | |
| CCO & MA affiliate(s) have developed, implemented, and participated in activities supporting a continuum of care that integrates Behavioral Health, Oral Health, and physical health interventions seamlessly across Medicare and Medicaid for FBDE members and access to care\* [Exh. B, Part 4, Sec. 2, Sec. 7 b, and Sec. 8; Exh. M, Sec. 1, 3, 6-25]  Plans ensure covered services are available, when Medically Appropriate and prioritize timely access to care and care coordination for high-risk members\* and ensure care coordination to ensure access to carved out Medicaid covered services\* [Exh. B, Part 4, Sec. 2, Sec. 8]  Written processes and monitoring in place to ensure accessibility services made available to FBDE members for all Medicare and Medicaid covered services in accordance with of Title II of the Americans with Disabilities Act, Title VI of the Civil Rights Act and in accordance with the 1999 *Olmstead* decision (<https://www.ada.gov/olmstead/olmstead_about.htm>) by assuring communication and delivery of Covered Services to Members with diverse cultural and ethnic backgrounds, as well as provision of care in the most integrated setting\* [Exh. B, Part 4, Secs. 2 and 8; Exh. K, Sec. 8]  Referral processes in place to ensure access to LTSS assessment with DHS Aging and People with Disabilities (APD)/Area Agency on Aging (AAA) or other LTSS providers for FBDE members who have potential need for LTSS services\* [Exh. B, Part 4, Sec. 2, Sec. 8, and Sec.9]  Process to monitor provider capacity and network adequacy to ensure access to covered Medicare and Medicaid services for FBDE members\* [Exh. B, Part 4, Sec. 3; Exh. B, Part 8, Sec. 6; and Exh. G, Sec. 1 and 2 ] | |  |  | |
| **Category 7 - Health Information Technology** | | | | |
| Tracking system in place to ensure provider Health Information Exchange (HIE) use, EHR adoption and event notifications use and to monitor adoption by network providers and alignment with HIT roadmap [Exh. J, Sec. 1 and 2]. Required for DSNP reporting.Chemicals with solid fill  Plans are using a Community Information Exchange (CIE) or other HIE tools for referrals and navigation to SDOH resources.  Ensure plans comply with the amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) [Exh. J, Sec. 3 and OAR 410-141-3591] | |  |  | |

**CCO Signature (must be authorized on the Signature Authorization Form)**

Authorized Signature Printed Name

Title Date

1. DSNP “look-alike” plans target dual eligible individuals but are not subject to integration requirements that benefit duals. The Centers for Medicare & Medicaid Services (CMS) continues to update regulations that limit MA organizations in offering D-SNP “lo​ok-alike” plan contracts. MA Plans that are not currently DSNPs should review the [CMS announcement of changes](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CY25_DSNP_LookAlike_Transition_Memo040524_G.pdf) and [CY2025 MA and Part D Final Rule](https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit) which will lower the Medicare Advantage D-SNP “look-alike” enrollee threshold from 80% to 70% in 2025 and to 60% in 2026, which means that plans with higher levels of enrollees entitled to Medicaid (i.e., dually eligible) are not being renewed.  [↑](#footnote-ref-1)