Division 141
OREGON HEALTH PLAN

410-141-3860
Care Coordination: Administration, Systems and Infrastructure

(1) Coordinated Care Organizations (CCOs) must coordinate services for members in accordance with 42 CFR §438.208, OAR 410-141-3865, OAR 410-141-3870 and this rule. This coordination must encompass all services accessed to address the member's physical, developmental, behavioral, dental and social needs (including Health-Related Social Needs (HRSN) and Social Determinants of Health and Equity (SDOH-E). To meet these requirements, CCO's must:

(a) Identify the needs of their members on an initial and ongoing basis as described in OAR 410-141-3865;

(b) Ensure coordinated services are provided to their members as described in OAR 410-141-3870; and

(c) Ensure their members are informed about the availability of Care Coordination and how to access or request it initially and ongoing.

(2) CCOs must ensure the overall coordination of all services and supports furnished to the member, regardless of who provides the service. CCOs are responsible for coordinating with Medicaid Fee-For-Service (FFS), Medicare or Medicare Advantage Plans, Community Mental Health Programs (CMHP), Oregon Department of Human Services (ODHS), including Aging and People with Disabilities (APD), Child Welfare (CW), and Developmental Disability Services (DDS), Oregon Department of Education (ODE), Oregon Youth Authority (OYA), Local Public and Mental Health Authorities and any other community and social support organizations.

(3) Primary responsibility for Care Coordination is determined based on the member's CCO Plan Type.

(a) If a member is enrolled in Plan Type CCOA or CCOB the CCO is primarily responsible for Care Coordination and must ensure the coordination of all services and supports furnished to the member by any other entity referenced in (2) of this rule.

(b) If a member is enrolled in Plan Type CCOE, CCOF or CCOG, the Oregon Health Authority's Medicaid Fee-For-Service (FFS) program is primarily responsible for Care Coordination. The CCO must proactively collaborate with FFS Care Coordination and other providers serving the member to maintain awareness of identified needs and existing Care Plans and to ensure the services covered by the CCO are coordinated.

(4) The entities in Section (2) of this rule may all have some level of responsibility for a member's care. Therefore, the fundamental role the CCO must fill is to facilitate, collaborate and oversee any relevant coordinating entities and lead when necessary as required in Section (3)(a) of this rule.

(5) When a member is engaged in multiple programs (e.g., Long Term Services and Supports, Intellectual and Developmental Disabilities, Child Welfare, Youth Wraparound, Intensive In-home Behavioral Health Treatment) where there are care teams or coordinators involved the CCO's responsibility is to collaborate with those entities who are coordinating services the member is receiving in order to reduce duplication and identify Care Coordination gaps.

(a) If the CCO is collaborating with another program the CCO is required to be aware of and document the coordinating entities activities to understand and identify additional unmet needs the member may have that require Care Coordination be provided by the CCO.

(b) The CCO is responsible for leading and facilitating Care Coordination for all needs identified that are not addressed or coordinated by another program or entity.

(6) Care Coordination is intended to continuously:

(a) Improve member health outcomes;

(b) Ensure a member's ability to live well with and manage any chronic conditions or disabilities;

(c) Improve member satisfaction;

(d) Reduce health inequities; and

(e) Reduce barriers to accessing health care.

(7) In all aspects of its systems and practice, Care Coordination must be:

(a) Person-centered and for minors, person-and family-centered;

(b) Trauma-informed and responsive;

(c) Culturally, linguistically and developmentally responsive and appropriate;

(d) Accessible to all members, including those with disabilities and persons who experience Limited English Proficiency and equitable access to services, consistent with 42 CFR §435.905 and ORS 413.550;

(e) Delivered with a whole-person approach that encourages member self-determination and autonomy;

(f) Designed to account for the unique contextual needs of various member populations in relation to their families and communities, such as children, youth, young adults, and older adults, so that every member's needs are identified and addressed in a way that is appropriate for their situation; and

(g) Focused on prevention, safety, early identification, intervention, and ongoing management.

(8) CCOs must develop and continuously improve the infrastructure (e.g., systems, technology solutions, processes, relationships, and agreements) needed to support, enable, and uphold their responsibility to coordinate services for their members. This infrastructure is not limited to, but must address:

(a) Management and implementation, including at minimum:

(A) Implementing and utilizing a care management platform to track and monitor care coordination activities (e.g., document, track, and report care plan goals and outcomes, members' care team, communication to/from care team, community resources, completed assessments and identified needs, change in health-related circumstances), communication with individual members, and timeliness of activities. To the maximum extent feasible, CCOs may establish system interfaces with community partners and providers.

(B) Implementing and utilizing member data to develop a risk stratification model and mechanism to stratify members by the following risk categories, at a minimum: no- or low-risk, moderate-risk, high-risk. The Oregon Health Authority (Authority) must approve CCOs' risk stratification mechanisms and algorithms before implementation.

(i) Data sources used to identify risk level and care gaps must include but are not limited to the following sources: claims and utilization data, Health Risk Assessments, functional need assessments, social needs and

risks, referrals, event notifications, and other available resources to inform physical, developmental, behavioral, and dental health needs;

(ii) Risk scores shall be utilized to inform the level of intensity and intervention required by the member and incorporated into the members care profile;

(iii) Continuous and ongoing data mining and identification of additional care gaps shall inform updates to the member's risk level and intervention needed.

(C) Regularly monitoring population level trends to determine and identify cohorts of the population requiring Care Coordination due to an emergent need;

(D) Developing monitoring mechanisms to regularly track timeliness, adequacy, and effectiveness of Care Coordination efforts and outreach by the CCO and providers, or subcontracted entity if Care Coordination is delegated;

(E) Tracking data required for reporting and ongoing improvement efforts;

(F) Maintaining policies, procedures, workflows, and desk processes to support CCO staff or subcontractors in managing Care Coordination activities;

(G) CCOs shall follow the grievance and appeal system requirements outlined in OAR 410-141-3875, OAR 410-141-3880, OAR 410-141-3885, OAR 410-141-3890, OAR 410-141-3895, OAR 410-141-3900, OAR 410-141-3905, OAR 410-141-3910, and OAR 410-141-3915 for grievances and appeals pertaining to Care Coordination.

(H) Abide by, or enter into as needed, any agreements or Memoranda of Understanding (MOUs) governing coordination with other entities described in (2) of this rule, including at minimum but not limited to, Aging and People with Disabilities (APD) or Type B Area Agency on Aging (AAA) for Long Term Services and Supports.

(I) Maintaining training and qualification requirements for CCO staff and subcontracted entities;

(J) Using creative and innovative strategies to develop and build member engagement;

(K) Maintaining a contact point for the escalation of emergent or unmet Care Coordination needs for use at any time by members, their representative or guardian, providers or other entities.

(b) Record keeping, mutual exchange of information, and privacy, including at minimum:

(A) Documentation and record keeping of member information in accordance with OAR 410-141-3520;

(B) The systems and processes (e.g., data sharing agreements, electronic health information exchange) needed for mutual exchange of information between the CCO, providers and community partners;

(C) Developing and entering into agreements or Memoranda of Understanding (MOUs) with providers and/or member serving systems or organizations not contracted with the CCO to ensure mutual exchange of information of a member's physical, behavioral, dental, and social needs information across all entities, providers, and systems involved in Care Coordination;

(D) Requiring Primary Care and other CCO contracted providers to communicate and coordinate care with each other and with the CCO in a timely manner, using electronic health information technology, as available, or through other mechanisms (e.g. paper-based systems); and

(E) The member having access to, and the ability to share, protected health information with others involved in their care as set forth in 45 CFR § 164.524.

(c) Access to Care, including at minimum:

(A) Establishing, maintaining and monitoring a network of participating providers to ensure the provision of an ongoing source of care appropriate to the needs of its members in accordance with OAR 410-141-3515;

(B) Contracting with Patient-Centered Primary Care Homes (PCPCH) to provide members a consistent and stable relationship with a care team, and supporting and collaborating with them in the overall coordination of the member's care;

(C) Developing and entering into agreements, memoranda of understandings (MOUs) with providers and other entities not contracted with the CCO, to ensure a member's access to coordinated physical, behavioral, dental, and social needs services across multiple providers;

(D) Using Value Based Payments to encourage specialty and Primary Care Providers to coordinate care;

(E) Assignment to a Primary Care Provider if the member has not selected a Primary Care Provider by the 90th day after enrollment in the CCO. The CCO shall provide notice of the assignment to the member and to the Primary Care Provider.

(i) A member may select a different Primary Care Provider at any time and/or request assistance with selecting an appropriate provider.

(ii) Eligible members who are American Indian/Alaska Native may select as their primary care provider:

(I) An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or

(II) An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.

(F) Maintenance of a policy and procedure that informs members, their Non-Emergency Medical Transportation (NEMT) providers and call centers of the availability of NEMT services for Care Coordination activities.

(d) Subcontractor and provider oversight, including at minimum:

(A) Ongoing and regular monitoring and reporting to ensure compliance, and appropriate support, for any delegated Care Coordination activities, in accordance with 42 CFR §438.208, OAR 410-141-3865, OAR 410-141-3870, and this rule;

(B) CCOs must take corrective action to address any deficiencies identified through monitoring and reporting.

(9) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a Care Coordination report submitted to the Authority under the timelines specified by the Authority in CCO Contract.

(a) The Authority shall provide tools and additional guidance specific to reporting requirements on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.

(b) The Authority may determine additional deliverables are necessary to appropriately oversee CCOs' implementation of Care Coordination requirements.

(10) If CCOs are not in compliance with these rules OHA may impose sanctions as described in CCO contract and OAR 410-141-3530.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727
History:
DMAP 37-2024, amend filed 01/25/2024, effective 02/01/2024
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DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

Please use this link to bookmark or link to this rule.

Health Systems Division: Medical Assistance Programs - Chapter 410

Division 141
OREGON HEALTH PLAN

410-141-3865
Care Coordination: Identification of Member Needs

(1) In order to coordinate a member's services as described in this rule, OAR 410-141-3860 and OAR 410-141-3870, Coordinated Care Organizations (CCOs) must have mechanisms in place to identify the member's physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity), goals, and preferences of members on an initial and ongoing basis.

(2) CCOs must conduct a Health Risk Assessment (HRA) within ninety (90) days of enrollment, or sooner if a member's health condition requires, and must:

(a) Conduct the HRA according to the evaluation checklist provided by the Oregon Health Authority (OHA) and available on the Quality Assurance Material Submission and Review page;

(b) Make the HRA available to members, their representative or guardian orally, in writing, or online;

(c) Document all attempts made to reach the member in accordance with OAR 410-141-3520;

(d) Review and document a member's HRA in their Care Profile or Care Plan, if applicable, in accordance with OAR 410-141-3870;

(e) Share with other entities and providers serving the member the results of any HRA to prevent duplication of those activities; and

(f) When the member, their representative or guardian has not returned or responded to the HRA, the CCO must:

(A) Follow up with the member if additional information, or support with completion, is needed. This shall include making a minimum of three (3) attempts to contact the member to facilitate completion and identification of the member's needs. The attempts to reach a member shall utilize at least two (2) mixed modalities (e.g., telephonic, text, email, letter), on different days, and at different times;

(B) Use other available data sources, including but not limited to those identified in OAR 410-141-3860(8) and (3) of this rule, to identify sufficient information to assign a risk level to the member; and

(C) Ensure services are coordinated for members regardless of their participation in or completion of the HRA.

(3) CCOs shall consider relevant information from a variety of sources to inform the development or update of a member's Care Profile, and/or Care Plan, if applicable, as described in OAR 410-141-3870 (4) and (5). This includes, but is not limited to:

(a) Progress notes from any entity involved in the members care coordination team;

(b) Any relevant assessments;

(c) New medical diagnoses, courses of treatment, and emergent needs;

(d) Social needs (including Social Determinants of Health and Health Related Social Needs)

(e) Utilization of services as a result of claims review;

(f) Information received from the member, their representative or guardian or other involved providers or community supports.

(g) Change in health-related circumstances which is defined as, but not limited to, any of the following occurrences:

(A) Hospital ER visits, hospital admissions or discharges;

(B) Mobile Crisis response;

(C) Pregnancy diagnosis;

(D) Chronic disease diagnosis;

(E) Behavioral health diagnosis;

(F) Intellectual/Developmental Disability (I/DD) diagnosis;

(G) Event that poses a significant risk to the member that is likely to occur or reoccur without intervention;

(H) Recent, or at risk for, homelessness or non-placement;

(I) Two or more billable primary ICD-10 Z code diagnoses within one (1) month;

(J) Two or more caregiver placements within past six (6) months;

(K) Discharge from a correctional facility, juvenile detention facility, other residential or long-term care settings back to the community or another care setting;

(L) Exit from Condition Specific Program or Facility as defined in OAR 410-141-3500;

(M) Enrollment or disenrollment in other service programs such as Long-Term Services and Supports, Intellectual/Developmental Disability services or Children's Intensive In-home services;

(N) Orders for Home Health or Hospice services;

(O) Newly identified or change to an identified Health Related Social Need (HRSN);

(P) An identified gap in network adequacy that leaves the member without a needed service or care;

(Q) Life span developmental transitions such as a transition from pediatric to adult health care;

(R) Entry into, or change of placement while in, foster care.

(4) CCOs must implement mechanisms, including but not limited to the HRA and any additional relevant assessments described above, to identify the risk category and needs for:

(a) Members with Special Health Care Needs (SHCN) as defined in OAR 410-141-3500; and

(b) Members requiring Medicaid Funded Long Term Services and Supports (LTSS) as defined in OAR 410-141-3500.

(5) If at any time the member is identified as potentially eligible for, or requiring LTSS, or having a Special Health Care Need, the CCO must also ensure those members are comprehensively assessed, per 42 CFR 438.208(c)(2), as soon as their health condition requires, to identify those members who have an ongoing special condition that requires either a course of treatment or regular care monitoring.

(6) CCOs must ensure appropriate and prompt referral of CCO-identified LTSS members to Oregon Department of Human Services (ODHS) Aging and People with Disability (APD) programs, the Office of Developmental Disabilities Services (ODDS), Local Mental Health Authorities (LMHA) or other service programs where appropriate.

Statutory/Other Authority: 414.615, 414.625, 414.635, 414.651 & ORS 413.042
Statutes/Other Implemented: ORS 414.610–414.685
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DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3870
Care Coordination: Service Coordination

(1) Coordinated Care Organizations (CCOs) must ensure all services accessed by members are coordinated according to the needs of members, following the requirements in OAR 410-141-3860, OAR 410-141-3865 and in this rule.

(2) Upon enrollment, CCOs must act promptly to ensure services are coordinated for members needing Urgent Care Services as defined in OAR 410-120-0000(270) or Emergency Services as defined in OAR 410-120-0000(95), even if the member has not yet selected a Primary Care Provider (PCP) or completed a Health Risk Assessment (HRA).

(3) CCOs must formally designate a person or team as primarily responsible to coordinate services accessed by the member and must provide information to the member on how to contact their designated person or team.

(4) CCOs shall utilize a Care Profile for all members as defined in OAR 410-141-3500.

(a) The member Care Profile must identify:

(A) The member's identifying and demographic information;

(B) The member's communication preferences and needs (e.g. preferred language, method of communication, Alternate Formats, Auxiliary Aids and Services);

(C) The member's care team, along with their contact information, role, and any assigned Care Coordination Responsibilities. This must include, but is not limited to;

(i) The person or team formally designated by the CCO as primarily responsible for coordinating the services accessed by the member;

(ii) All providers serving the member, including, at minimum, their Primary Care Provider; and

(iii) The appropriate individuals from all entities serving the member, such as those listed in 410-141-3860(2).

(D) The member's needs, goals and preferences determined on an initial and ongoing basis as described in OAR 410-141-3865;

(E) The member's health risk score and risk category as described in OAR 410-141-3860;

(F) Any open or closed Care Plans; and

(G) An overview of the supports, services, activities, and resources deployed to meet the member's identified needs.

(b) Upon a change in health-related circumstances, as described in OAR 410-141-3865(3)(g), the CCO must update the members Care Profile, determine if the development of a Care Plan is warranted and document the outcome and actions of the determination.

(5) CCOs must ensure services are actively coordinated for members when requested by the member, their representative or guardian, an involved provider or entity, or when required by the member's needs as identified in the members Care Profile. This coordination is accomplished through the development and implementation of a Care Plan that scales in complexity relative to the needs, goals, preferences, and circumstances of the member.

(a) CCOs shall consider the member's identified risk category to determine if a Care Plan is needed.

(A) Members in the no- or low-risk category do not require a Care Plan unless the member's needs change resulting in a higher risk category or when the member requests it;

(B) Members within the moderate-risk and high-risk categories must have a Care Plan developed.

(b) The Care Plan is developed, or revised as required in (5)(d) of this rule:

(A) In alignment with the member's needs, goals, preferences, and circumstances as detailed in the care profile;

(B) By incorporating information from any relevant assessments, treatment and service plans from providers involved in the member's care, and if appropriate and with consent of the member or the member's representative or guardian, information provided by community partners;

(C) In consultation with any other provider, case manager, or entity providing services to, or coordinating care for, the member;

(D) In consultation with a clinician that has the appropriate qualifications and clinical practice history to review and revise the Care Plan considering the members' complex physical, developmental, behavioral or dental health care needs;

(E) In accordance with a members updated risk level as described in (4)(a)(E) of this rule.

(F) With the member, their representative or guardians participation to the extent they desire or are able. The member, their representative or guardian may be satisfied with and understand the Care Plan, including any of their own roles and responsibilities.

(i) If participation in creating a member's Care Plan may be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a Care Plan;

(ii) The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to address the concern(s);

(iii) This decision must be reviewed prior to each significant Care Plan update resulting from a health-related circumstance change as set forth in OAR 410-141-3865(3)(g). The decision to continue the exclusion shall be documented.

(G) In accordance with state quality assurance and utilization review standards, as applicable.

(c) Upon completion of the Care Plan, CCOs must make it promptly available to the member, the members representative or guardian and to all relevant providers rendering services to the member who shall coordinate and provide services according to:

(A) The member, the member's representative or guardian must be provided immediate electronic access, or a copy in the member's preferred method of communication and in the member's preferred language. Auxiliary Aids and Services and Alternate Formats must be made available upon request of the member at no cost within five (5) business days of the request.

(B) If the CCO requires Care Plans to be approved, approval must be timely, according to a member's needs; and

(C) If providing the member with a copy of or access to their full Care Plan may be significantly detrimental to their care or health, as determined by the member's care team, CCOs may withhold from the member, only those parts of the plan that are determined to be detrimental. CCOs must document the reasons for withholding the full or partial Care Plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to address the concern(s). This decision to withhold the Care Plan in full or in part must be reviewed prior to each plan update, and the decision to continue withholding the Care Plan in full or in part shall be documented.

(d) Open Care Plans must be reviewed and revised at least annually, or

(A) When a member, member representative or guardian, or any provider serving the member requests a review and revision; or

(B) Upon a change in health-related circumstances as described in OAR 410-141-3865 (6)(g).

(e) The Care Plan may be closed and the member shall continue with Care Profile tracking only when;

(A) Requested by the member, their representative or guardian; or

(B) No longer warranted by the member's risk category or circumstances;

(C) There is no contact with the member, their representative or guardian after a minimum of three (3) attempts of outreach, utilizing at least two mixed modalities (e.g., telephonic, text, email, letter) over a sixty (60) day period , and with consultation and agreement of all available care team members.

(6) CCOs shall ensure Care Coordination for all members, regardless of where the member is receiving services.

(a) If members experience a Care Setting Transition CCOs must ensure:

(A) Members are transitioned into the most appropriate independent and integrated community settings and provided follow-up services as medically necessary and appropriate prior to discharge to facilitate successful handoff to community providers;

(B) Appropriate discharge planning and care coordination for adults who were members upon entering the Oregon State Hospital and who shall return to their home CCO upon discharge from the Oregon State Hospital;

(C) Coordination of care and discharge planning for out of service area placements, for which an exception shall be made to allow the member to retain Home CCO enrollment while the member's placement is a temporary residential placement as defined in OAR 410-141-3500, or elsewhere in accordance with OAR 410-141-3815. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan.

(b) Coordinate and authorize care when it has been deemed medically appropriate and medically necessary to receive services outside of the service area because a provider specialty is not otherwise contracted with the;

(c) Coordinate the members care when they are temporarily outside their enrolled service area;

(d) If members are transitioning between CCOs or CCO to fee-for-service (FFS) as set forth in OAR 410-141-3850;

(e) Post Hospital Extended Care must be provided in accordance with OAR 411-070-0033:

(A) Post Hospital Extended Care Coordination (PHEC) is a twenty (20) day benefit included within the Global Budget and the CCO shall pay for the full twenty (20) day PHEC benefit when the full twenty (20) days is required by the discharging provider. CCOs shall make the benefit available to non-Medicare Members who meet Medicare criteria for a post-Hospital Skilled Nursing Facility placement.

(B) CCOs shall notify the Member's local DHS APD office as soon as the Member is admitted to PHEC. Upon receipt of such notice, CCO and the Member's APD office must promptly begin appropriate discharge planning.

(C) CCOs shall notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no less than two (2) full days prior to discharge.

(D) CCOs shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to Durable Medical Equipment (DME), medications, home and Community based services, discharge education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to:

(i) attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; or

(ii) schedule follow-up care appointments with Providers that the Member may need to see;

(iii) or both (i) and (ii).

(E) CCOs shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at www.medicare.gov/publications

(F) CCOs are not responsible for the PHEC benefit unless the Member was enrolled with the CCO at the time of the hospitalization preceding the PHEC facility placement.

(7) In addition to the care planning requirements above, for LTSS or Special Health Care Needs members as defined in OAR 410-141-3500 that are assessed according to OAR 410-141-3865(5) to have an ongoing special condition that requires a course of treatment or regular care monitoring or identified as high risk:

(a) CCOs must consider the above members, according to their needs, during Interdisciplinary Team Meetings which are convened and facilitated twice per month or more frequently, as needed, including a post-transition meeting of the interdisciplinary team within fourteen (14) days of a transition between levels, settings or episodes of care. These meetings must:

(A) Include the member, their representative or guardian, unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with (5)(b)(F) of this rule;

(B) Consider relevant information from all providers; and

(C) Provide a forum to:

(i) Describe the clinical interventions recommended to the treatment team;

(ii) Create a space for the member to provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meeting;

(iii) Identify coordination gaps and strategies to improve care coordination with the member's service providers;

(iv) Develop strategies to identify, monitor and follow up on needed referrals for specialty care, routine health care services (including medication monitoring), other community programs or social need services; and

(v) Align with and update the member's individual Care Plan and share the plan in accordance with (5)(c) of this rule.

(b) CCOs must implement a mechanism to provide direct access to specialists, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685
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DMAP 37-2024, amend filed 01/25/2024, effective 02/01/2024
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