Division 141
OREGON HEALTH PLAN

410-141-3500
Definitions

(1) The following definitions apply with respect to OAR chapter 410, division 141. The Oregon Health Authority (Authority) also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.

(2) “Adjudication” means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final Managed Care Entity (MCE) claims decision or the Authority issuing a final hearings decision. For a final Managed Care Entity (MCE) claims decision, the date of “Adjudication” is the date on which an MCE has both (a) processed and (b) either paid or denied a Member’s claim for services.

(3) “Aging and People with Disabilities (APD)” means the division in the Oregon Department of Human Services (ODHS) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.

(4) “Area Agency on Aging (AAA)” means the designated entity with which the ODHS contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.

(5) “The Authority” means the Oregon Health Authority (OHA).

(6) “Alternate Format” means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; Centers for Medicare and Medicaid Services (CMS) Section 1557 of the Affordable Care Act (ACA) outlines requirements for health plans and providers on alternative formats.

(7) “Auxiliary Aids and Services” means services available to members as defined in 45 Code of Federal Regulations (CFR) Part 92.

(8) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.

(9) “Benefit Period” means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and The Authority are in effect.

(10) “Business Day” means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.

(11) “Capitated Services” means those covered services that an Managed Care Entity (MCE) agrees to provide for a capitation payment under contract with the Authority.

(12) “Capitation Payment” means monthly prepayment to an Managed Care Entity (MCE) for capitated services to Managed Care Entity (MCE) members.

(13) “Care Coordination” means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member. Care Coordination requirements are described in OAR 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with CFR 438.208.

(14) "Care Plan" means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the member's providers, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs. Care Plan requirements are described in OAR 410-141-3865 and 410-141-3870.

(15) "Care Profile" means the electronic record a CCO develops and maintains for all members. The Care Profile is the platform that receives feeds from different data sources used to identify, track and manage a member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the member. Care Profile requirements are further described in OAR 410-141-3865 and OAR 410-141-3870.

(16) "Care Setting Transitions" means a transition between different locations, settings or levels of care.

(17) "Coordinated Care Organization Payment or CCO Payment" means the monthly payment to a Coordinated Care Organization (CCO) for services the CCO provides to members in accordance with the global budget.

(18) "Certificate of Authority" means the certificate issued by Department of Consumer and Business Services (DCBS) to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(19) "Client" means an individual found eligible to receive Oregon Health Plan (OHP) health services, whether or not the individual is enrolled as an CCO member.

(20) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.572 and in accordance with criteria specified in ORS 414.575. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:

(a) In a Service Area where only one (1) federally recognized tribe exists, the CCO shall seek one (1) tribal representative to serve on the CAC;

(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one (1) tribal representative from each tribe to serve on the CAC; and

(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.

(21) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.

(22) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:

(a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to;

(A) Alcohol;

(B) Illicit Drugs; and

(C) Gambling.

(b) Physical Health conditions, including but not limited to:

(A) Cancer;

(B) Diabetes;

(C) Bariatric Ie.

(c) Developmental Disabilities.

(23) “Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.

(24) “Contract” means an agreement between the State of Oregon acting by and through The Authority and a Managed Care Entity (MCE) to provide health services to eligible members.

(25) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

(26) “Coordinated Care Services” mean a Managed Care Entity’s (MCE) fully integrated physical, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) services.

(27) “Corrective Action” or “Corrective Action Plan (CAP)” means an Authority-initiated request for a Managed Care Entity (MCE) or a Managed Care Entity (MCE)-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(28) “Culturally and Linguistically Responsive and Appropriate Services” means the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and Linguistically appropriate services are further defined in 42 CFR § 59.2.

(29) “Delivery System Network (DSN)” means the entirety of those Participating Providers who:

(a) Contracts with; or

(b) Are employed by, a CCO for purposes of providing services to the Members of such CCO. “Provider Network” has the same meaning.

(30) “Dental Care Organization (DCO)” has the meaning as provided for in ORS 414.025 (24).

(31) “Dental Health” means conditions of the mouth, teeth, and gums.

(32) “Department” means the Oregon Department of Human Services (ODHS).

(33) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection department.

(34) “Disenrollment” means the act of removing a member from enrollment with an MCE.

(35) "Diversity of the workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.

(36) “Encounter Data” means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818 and under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided:

(a) Were covered services, non-covered services, or other Health-Related Social Needs services; or

(b) Were not paid; or

(c) Paid for on a Fee- For-Service or capitated basis; or

(d) Were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and

(e) Were performed pursuant to Subcontractor agreement, special arrangement with a facility or program, or other arrangement.

(37) “Enrollment” means the assignment of a member to a Managed Care Entity (MCE) for management and coordination of health services.

(38) “Family Planning” means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health Plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Prescription contraceptives (such as birth control pills, patches or rings);

(d) IUDs and implantable contraceptives and the procedures requires to inserted remove them;

(e) Injectable hormonal contraceptives (such as Depo-Provera);

(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);

(g) Laboratory tests including appropriate infectious disease and cancer screening;

(h) Radiology services;

(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.

(39) “Flexible Services” means those services that are cost-effective services offered as an adjunct to covered benefits.

(40) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(41) “Grievance System” means the overall system that includes:

(a) Grievances to a Managed Care Entity (MCE) on matters other than adverse benefit determinations;

(b) Appeals to a Managed Care Entity (MCE) on adverse benefit terminations; and

(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.

(42) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(43) “Health-Related Services (HRS)” means non-covered services under Oregon’s Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.

(44) “Health Risk Assessment (HRA)” means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a member, their representative or guardian about key areas of their health, including their physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health). The HRA is intended to inform the coordination of services and supports that meet the members individualized needs as described in OAR 410-141-3860, 410-141-3865 and 410-141-3870.

(45) “Health System Transformation” means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of Oregon Health Plan (OHP).

(46) “Home CCO” means the CCO enrollment situation that existed for a member prior to placement, including services received through Oregon Health Plan (OHP) fee-for-service, based on permanent residency.

(47) “Indian” and/or “American Indian/Alaska Native (AI/AN)” means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).

(48) “Indian Health Care Provider (IHCP)” means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

(49) “In Lieu of Service” (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).

(50) “Individual with Limited English Proficiency” means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

(51) “Institution for Mental Diseases (IMD)” means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(52) “Legal Holiday” means the days described in ORS 187.010 and 187.020.

(53) “Licensed Health Entity” means a Managed Care Entity (MCE) that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(54) “Managed Care Entity (MCE)” is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.

(55) “Managed Care Organization (MCO)” is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.

(56) “Material Change to Delivery System” means:

(a) Any change to the CCO’s Delivery System Network (DSN) that may result in more than five (5) percent of its members changing the physical location(s) of where services are received; or

(b) Any change to CCO’s DSN that may likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sol provider specialty type; or

(c) Any change in CCO’s overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO’s total Members or Provider Network or both; or

(d) Any combination of the above changes.

(57) “Medicaid-Funded Long-Term Services and Supports (LTSS)” means all Medicaid funded services CMS defines as long-term services and supports, including both:

(a) “Long-term Care,” the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;

(b) “Home and Community-Based Services,” the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.

(58) “Member” means an Oregon Health Plan (OHP) client enrolled with a CCO.

(59) “Member Representative” means an individual who can make Oregon Health Plan (OHP)-related decisions for a member who is not able to make such decisions themselves.

(60) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(61) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.

(62) “Ombudsperson Services” means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.

(63) “Oregon Health Plan (OHP)” means Oregon’s Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon’s Medicaid program or a related state-funded health program, or both.

(64) “Oregon Integrated and Coordinated Health Care Delivery System” means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.570.

(65) “Participating Provider” means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. “Network Provider” has the same meaning as Participating Provider.

(66) “Patient-Centered Primary Care Home (PCPCH)” means a recognized clinic that takes a patient and family-centered approach to all aspects of care. PCPCHs work with the member and their health care team to improve and coordinate care and help to eliminate repetitive procedures. As defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040 and means the definition as set forth in OAR 409-055-0010.

(67) “Permanent Residency” means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.

(68) “Plan Type” means the designation used by the Authority to identify which health care services covered by a client’s OHP Plus or equivalent benefit package are paid by a CCO, by the Authority’s fee-for-service program, or both. If a client does not have a plan type designation, then all of the client’s health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:

(a) CCOA: Physical, dental, and behavioral health services are paid by the client’s CCO;

(b) CCOB: Physical and behavioral health services are paid by the client’s CCO. Dental services are paid the fee-for-service program;

(c) CCOE: Behavioral health services are paid by the client’s CCO. Physical health and dental services are paid by the fee-for-service program;

(d) CCOF: Dental services are paid by the client’s CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120. Any reference to CCOF means the benefit package covers dental services only; and

(e) CCOG: Dental and behavioral health services are paid by the client’s CCO. Physical health services are paid by the fee-for-service program.

(69) “Post Hospital Extended Care Services” (PHECS). Consistent with 42 USC § 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than three (3) consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a

member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility:

(a) Within thirty (30) days after discharge from such hospital; or

(b) Within such time as it may be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care may not be medically appropriate within thirty (30) days after discharge from a hospital; and

(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within thirty (30) days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.

(70) “Potential Member” means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.

(71) “Primary Care Provider (PCP)” means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:

(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;

(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-055-0010 and OAR 410-120-0000.

(72) “Provider” means an individual, facility, institution, corporate entity, or other organization that:

(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or

(b) Bills, obligates, and receives reimbursement from the Authority’s Health Services Division on behalf of a Provider, (and also termed a “Billing Provider”); and

(c) Supplies health services or items (also termed a “Rendering Provider”).

(73) “Readily Accessible” means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(74) “Service Area” means the geographic area within which the MCE agreed under contract with the Authority to provide health services.

(75) “Serious Emotional Disorder” (SED) means a subpopulation of individuals under age 21 who meet the following criteria:

(a) An infant, child or youth, between the ages of birth to 21 years of age; and

(b) Must meet criteria for diagnosis, functional impairment and duration:

(A) Diagnosis: The infant, child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM “V” codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):

(i) For children three (3) years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);

(ii) For children four (4) years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).

(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;

(C) Duration: The identified disorder and functional impairment must have been present for at least one (1) year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than one (1) year.

(76) Social Determinants of Health and Equity (SDOH-E) each has the meaning provided for in OAR 410-141-3735.

(77) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders and either:

(a) Have functional disabilities;

(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or

(c) Are a Prioritized Population member. This includes members who:

(A) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;

(B) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);

(C) Are children ages 0-5:

(i) Showing early signs of social/emotional or behavioral problems; or

(ii) Have a Serious Emotional Disorder (SED) diagnosis.

(D) Are in medication assisted treatment for SUD;

(E) Are women who have been diagnosed with a high-risk pregnancy;

(F) Are children with neonatal abstinence syndrome;

(G) Children in Child Welfare;

(H) Are IV drug users;

(I) People with SUD in need of withdrawal management;

(J) Have HIV/AIDS or have tuberculosis;

(K) Are veterans and their families;

(L) Are at risk of first episode psychosis;

(M) Individuals within the Intellectual and developmental disability (IDD) populations.

(78) “Subcontract” means either:

(a) A contract between a CCO and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the CCO under its contract with the State; or

(b) Is the infinitive form of the verb “to Subcontract”, i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.

(79) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.

(80) “Transition of Care” applies to Medicaid members who are enrolled in a CCO (“the receiving CCO”) immediately after disenrollment from a “predecessor plan” which may be another CCO (including disenrollment resulting from termination of the predecessor CCO’s contract) or Medicaid fee-for-service (FFS). Transition of Care does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan. Meets the standards pursuant to OAR 410-141-3850.”

(81) “Trauma Informed Approach” means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.

(82) “Temporary Placement” means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.

(83) "Trauma-informed services" means those services provided using a Trauma Informed Approach.

(84) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that shall be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member’s family, or the member’s representative.

(85) “Urban Indian Health Program” (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.

(86) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.

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
DMAP 8-2023, minor correction filed 03/01/2023, effective 03/01/2023
DMAP 89-2022, amend filed 12/16/2022, effective 01/01/2023
DMAP 60-2022, amend filed 06/24/2022, effective 07/01/2022
DMAP 56-2021, amend filed 12/30/2021, effective 01/01/2022
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 55-2019, adopt filed 12/17/2019, effective 01/01/2020

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Health Systems Division: Medical Assistance Programs - Chapter 410

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
DMAP 28-2021, amend filed 06/28/2021, effective 07/01/2021
DMAP 6-2021, temporary amend filed 02/10/2021, effective 02/10/2021 through 08/08/2021
DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 1-2020, temporary amend filed 01/02/2020, effective 01/02/2020 through 06/29/2020
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

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
History:
DMAP 37-2024, amend filed 01/25/2024, effective 02/01/2024
DMAP 89-2022, amend filed 12/16/2022, effective 01/01/2023
DMAP 56-2021, amend filed 12/30/2021, effective 01/01/2022

DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

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Health Systems Division: Medical Assistance Programs - Chapter 410

Division 141
OREGON HEALTH PLAN

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
History:
DMAP 37-2024, amend filed 01/25/2024, effective 02/01/2024
DMAP 56-2021, amend filed 12/30/2021, effective 01/01/2022
DMAP 62-2020, amend filed 12/16/2020, effective 01/01/2021
DMAP 1-2020, temporary amend filed 01/02/2020, effective 01/02/2020 through 06/29/2020
DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

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