Care Coordination/ICC Learning Collaborative

April 21, 2022

Oregon Health Authority

Today's Agenda

Time	Topic	Presenter
Noon	Welcome & Meeting Logistics	Jackie Wetzel
12:05 pm	OARs and CCO contract requirements	• Dave Inbody • Carrie Williamson
1pm	Break	
1:10 pm	OARs and CCO contract requirements (continued)	• Carrie Williamson • OHA Health Systems Division Behavioral Health and Medicaid Representatives
1:50 – 2pm	Wrap up & feedback from participants	All

Learning Collaborative (LC) Format

12-month, virtual learning community and forum to support CC/ICC

- Sessions are **not** being recorded
  - Open, candid communication – but please no PHI
  - Session materials will be posted to the OHA Transformation Center- Care Coordination page after each meeting
- LC limitations and plan for ongoing communication to participants
- Input is welcome between sessions:
  - Jackie.Wetzel@state.or.us (OHA Transformation Center)
  - Dsimnitt.dsc@gmail.com (LC Facilitator)

Zoom Logistics

Throughout this learning collaborative, please:

- Use your webcam whenever possible
- Mute your microphone unless you are speaking
- Use the ‘raise hand’ function to share information or ask a question
- Add information and questions to the chat
- If you are having technical Zoom issues, send a chat message directly to Tom Cogswell
- Participate! Collaborate! Engage!

Please do not put your call “on hold” if you are dialed in.

OAR Questions

Dave Inbody
CCO Operations Manager
OHA Health Authority

CCO Requirements

CCO Contract Exhibit B, Part 4, Section 7b:

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

Non-Covered Health Services with Care Coordination

CCO Contract Exhibit B, Part 2, Section 9:

(a) Except as provided in Sec. 10 below of this Ex. B, Part 2, Contractor shall coordinate services for each Member who requires health services not covered under this Contract…

CCO Contract Exhibit B, Part 2, Section 10:

Non-Covered Services for which Contractor is not required to provide Care Coordination include, but are not limited, to:

- Physician assisted suicide
- Hospice services for Members who reside in a Skilled Nursing Facility
- School-Based Health Services
- Administrative examinations requested by an CAF, APD, AMH, OYA, Child Welfare branch office or approved by the Division of Medical Assistance Programs
- Services provided to CWM or CWM Plus recipients
- Abortions

…but CCO needs to ensure member has access to NEMT

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OAR Questions: 410-141-3865

Coordination of Care Transitions Policy

"What is intent of the requirement in OAR 410-141-3865 (12)?

(a) and (b) seem to be specific to discharges from a behavioral health facility, however, (c) and (d) are not as clear."

Can you help us get clear guidance on whether or not these rules are related to BH admissions/discharges or are they for ANY inpatient admission/discharge. There is a huge difference as far as staffing resources and oversight to meet these requirements for ANY inpatient admission/discharge. Are there any other disease/condition specific hospitals in our state? Shriner's Children's Hospital is the only one that comes to my mind."

OAR Questions: 410-141-3865

"What is intent of the requirement in OAR 410-141-3865 (12)?

•We are looking for help with interpreting the intent of the requirement in OAR 410-141-3865 Care Coordination Requirements, specifically 12 C&D.

•We are unclear if the face-to-face requirement is specific to BH or if it encompasses all inpatient stays and long-term care facilities."

OHA Response 410-141-3865

Care Coordination described in 410-141-3865(12)(c)&(d) applies to any discharge, not just behavioral health

(12) CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860 (Integration and Coordination of Care), care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below.

(c) For discharges from an acute care admission…

(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility…

OAR 410-141-3865 (12)

(12) CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860 (Integration and Coordination of Care), care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below.

(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities.

(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:

OAR 410-141-3865 (12)

(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;

(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and

(C) Engage with the member, face to face, within two days post discharge.

(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on a face-to-face basis whenever possible, as follows:

(A) Within one business day of admission;

(B) Two times per week while the member is in acute care; and

(C) No less than two times per week within the week of discharge

OAR 410-141-3865 (12)

(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;

OAR Questions 410-141-3870 (10)(c)

Comment from learning collaborative participant:

"Sharing the screening assessment findings is not trauma informed."

OHA Response:

The OAR requires that CCOs notify members who are eligible for ICC with details of the ICC program and the name and contact information of the member's assigned ICC care coordinator.

OAR 410-141-3870(9)(b)(K)

The inclusion criteria for ICC rescreening is broad and results in rescreening for any encounter billed as a Z code.

"Two or more billable primary Z code diagnoses within one month."

OHA Response:

OAR 410-141-3870(9)(a)

For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan,

CCO Requirements

Question from a provider:

What are the limits of CCO-provided care coordination?

OHA Response:

CCOs are responsible for ensuring that care coordination occurs, even if CCOs do not directly provide it. (Exhibit B, Part 4, Section 7b)

Thank You

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Upcoming Sessions

- **May 19: Traditional Health Workers (THWs)**
  - Brief overview of THW program
  - THW panel presentations
  - Q&A
- **June 16: Pediatric Care Coordination**
  - County demonstration project overview
  - Transitions of care
- **July 21: OHA Data for CC/ICC**
  - Collective tool
  - Children's Health Complexity Data
  - Other/recommendations/data wish list
- **Aug 18: Combined Session with PCPCH Practices**
  - Overview on program approaches and strategies for coordinating care
  - Successes and challenges of coordination between CCOs and PCPCHs

THANK YOU!

See you next month
May 19, Noon – 2pm

Please provide session feedback here:

https://forms.office.com/r/dmYW44DPe9

Or using the QR code function on your phone:

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