CCO 2.0 RFA Appendix C: Administrative Rule Concepts

A. Value Based Purchasing

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	CCO VBP targets that achieve 70% VBP by 2024 CCOs must increase annually the level of payments that are to ~~providers~~Providers in contracts that include a ~~value-based payment~~Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" Pay for Performance category LAN category 2C or higher. In addition to the LAN Framework, CCOs will use the ~~OHA□σ ξαλυε βασεδ Παψμεντ Χατεγοριζατιον Γυιδανχε~~OHA's Value-Based Payment Categorization Guidance. CCOs must meet minimum annual VBP thresholds, according to the following schedule: • For services provided in 2020, no less than 20% of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher; • For services provided in 2021, no less than 35% of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher; • For services provided in 2022, no less than 50% of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher; • For services provided in 2023, no less than 60% of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher; it is expected that and no less than **20%** of the CCO's payments to ~~providers~~Providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher and will qualify as a part of	Definition of VBP and LAN in 410-141-3000 410-141-3015 (25) CCOs are encouraged to use alternative payment methodologies consistent with ORS 414.653. The ~~applicant~~Applicant shall describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for ~~members~~Members.

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OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	the VBP annual target; and • For services provided in 2024, no less than 70% of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher and no less than **25%** of the CCO's payments to ~~providers~~Providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher and will qualify as a part of the VBP annual target.	
	VBP programs may not negatively impact access or services for priority populations, including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees as well as populations at the intersections of these groups.	
	CCOs are required to begin CCO 2.0 – January 2020 – with at least 20% of their projected annual payments to their ~~providers~~Providers in contracts that include a ~~value-based payment~~Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" Pay for Performance category LAN category 2C or higher. In addition to the LAN Framework, CCOs will use the ~~OHA□σ ςαλυε βασεδ Παψμεντ Χατεγοριζατιον Γυιδανγε~~OHA's Value-Based Payment Categorization Guidance	New Rule 410-141-VBP1
	OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. OHA will consider the absolute value of all risk settlements (which would turn a negative payment to a positive payment) and use that absolute value for the numerator. The denominator would remain the same: total	

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OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	~~member~~Member expenditures as reported in Exhibit L.	
	Administrative/overhead expenses, and other non-service related expenditures are excluded from the calculation. CCOs shall, to the extent possible, report detailed financial information of ~~sub-contractors~~Subcontractors' actual incurred medical costs and non-medical costs in compliance with 42 CFR §438.8(e)(2)(v). The denominator used for calculating VBP percentages will exclude non-medical and administrative costs.	
	CCOs will maintain necessary information technology infrastructure for VBP reporting	
	CCOs will implement a Patient-Centered Primary Care Home (PCPCH) VBP by the beginning of calendar year 2020. The PCPCH PMPM payment counts for this requirement at a **Category 2A (Foundational Payments for Infrastructure & Operations)** level, as defined by the LAN Framework.	
	CCOs are required to provide per-~~member~~Member-per-month (PMPM) payments to their PCPCH clinics as a supplement to any other payments made to PCPCHs, regardless of other payment arrangements	
	CCOs will vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs and payments increase over time, by tier level.	
	PMPMs must be meaningful amounts to support clinic sustainability	
	CCOs will annually report all VBP data to the All Payer All Claims Database (APAC).	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	CCOs will implement ***two new or expanded VBPs*** in the following care delivery areas: ~~hospital~~Hospital care, maternity care, children's health care, Behavioral Health care, and oral health care Required VBPs in care delivery areas must fall within LAN **Category 2C (Pay for Performance) or higher** through the duration of the CCO 2.0 period, according to the following schedule: CCOs must implement care delivery area VBPs, according to the following schedule: - **2020:** CCO shall develop and plan two new, or expanded from an existing contract, VBPs. The two new or expanded VBPs must be in two of the care delivery areas listed above, and one of the areas must be either ~~hospital~~Hospital care or maternity care. A CCO may design new or expanded VBPs in both ~~hospital~~Hospital care and maternity care. A VBP may encompass two care delivery areas (i.e. children's mental health VBP). - **2021:** CCO shall implement the two new or expanded VBPs developed in 2020. - **2022:** CCO shall implement a new or expanded VBP in one more care delivery area. By the end of 2022, new or expanded VBPs in both ~~hospital~~Hospital care and maternity care must be in place. - **2023 and 2024:** CCO shall implement one new or expanded VBP each year in each of the remaining care delivery areas. By the end of 2024, new or expanded VBPs in all five care delivery areas.	
	Year 2 and beyond care delivery area VBP specifications can be specified in later rule changes	

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OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	CCOs must comply with the following reporting requirements: **a.** In January, February, or March 2021 (OHA will determine the deadline), CCOs must submit summary data stratified by LAN categories that describes 2020 payment arrangements. Although the CCO will likely be unable to report exactly all adjudicated payments made for 2020, OHA will require the fee-for-service payments that are associated with a VBP in order to directionally assess the CCO's preliminary progress towards meeting the VBP targets. This will function as a rolled-up version of Appendix G (before Appendix G data are available) and will allow for more timely monitoring of the CCO's progress towards achieving the VBP targets. This report will also serve as a comparison for what the CCO reported in the RFA. Note: Data submitted to Appendix G and H, which allows for a nine-month lag after the reported time period, will be the official assessment of a CCO's VBP target achievement. **b.** Describe the specific quality metrics from the HPQMC Aligned Measures Menu, or HPQMC Core Measure Set, if developed in future years, that will be used, including the established benchmarks that will be used for performance-based payments to ~~providers~~Providers and other relevant details; and /or **c.** If the aligned measure set does not include appropriate metric/s for planned VBP, CCO ~~applicants~~Applicants may request approval from OHA to use other metrics, preferably those defined by the National Quality Forum (NCF).	

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OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	d. Should OHA contract with one or more other CCOs serving ~~members~~Members in the same geographical area, the CCO shall participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's value-based purchasing ~~provider~~Provider contracts for common ~~provider~~Provider types and specialties. OHA shall inform the CCO of the ~~provider~~Provider types and specialties for which the performance measures shall be discussed. Each CCO shall incorporate all selected measures into applicable ~~provider~~Provider contracts. **2.** ~~B.~~ By September 30, 2020, CCOs must annually submit payment arrangement data via APAC's Appendices G and H. Please see APAC Reporting Guide for additional information. **3.** ~~C.~~ Report PCPCH VBP details including: **a.** Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020); **b.** Payment differential and/ or range by PCPCH tier levels over CY 2 (2021) through CY5 (2024); and **c.** Rationale for approach (including factors used to determine the rate such as ~~rural /urban~~Rural /Urban, social complexity). **d.** Although OHA is not defining a specific minimum dollar amount, the payments should meaningfully support clinics efforts to support patient-centered care. **4.** ~~D.~~ By Spring/Summer, CCO's executive leadership team must engage in interviews with OHA to:	

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OHPB #10 (VBP): Increase CCOs' use of ~~value-based payments~~Value-Based Payments (VBP) with their contracted ~~providers~~Providers		
	a. Describe how the first year of activities and VBP arrangements compare to that which was reported in the RFA, including detailed information about VBP arrangements and LAN categories; **b.** Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was reported in the RFA; and **c.** Report implementation plans for the two care delivery areas that will start in 2021; and **d.** Any additional requested information on VBP development and implementation.	
	OHA may publish each CCO's VBP data and other data relating to individual CCOs care delivery areas, PCPCH payments, and other details	

B. ~~COST~~Cost

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #12 (COST): Incorporate measures of quality & value in any OHA-directed payments to providers (e.g. ~~hospital~~Hospital payments) or OHA reimbursement policies and **align measures** with CCO metrics	CCOs shall make qualified directed payments for a DRG ~~hospital~~Hospital Quality and Access pool beginning January 1, 2020, depending on the 2019-21 Legislatively Adopted Budget.	410-125-0230 Qualified Directive Payments – add DRG Hospitals 410-141-3420 Managed Care Entity (MCE) Billing 410-120-1295 Non-Participating Provider
OHPB #13 (COST): Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development to: • Align incentives for CCOs, providers, and communities to achieve quality metrics, and **Create consistent reporting of all CCO expenses** related to medical costs, incentive arrangements, and other payments regardless of funding source (~~quality pool~~Quality Pool or ~~global budget~~Global Budget)	CCOs will clearly report all quality or incentive payments to ~~providers~~Providers (including SDOH-HE and public health partners as appropriate), as distinct from any base payment to ~~providers~~Providers the ~~providers~~Providers would have received absent a quality incentive. CCOs will create and publish a distribution plan for ~~quality pool~~Quality Pool earnings that provides OHA and ~~community~~Community partners understanding of the methodology and decision-making process the CCO will use to distribute ~~quality pool~~Quality Pool revenues to ~~providers~~Providers partners, including SDOH-HE partners, public health partners, and other ~~health-related service providers~~Health-Related Service Providers. The distribution plan should also explain decision making for ~~quality pool~~Quality Pool funds that are retained by the CCO. CCOs will be required to submit plan within 60 days of receiving final ~~quality pool~~Quality Pool distribution	
OHPB #14 (COST): Address increasing pharmacy costs and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers	Using OPDP as a PBM will satisfy compliance with PBM transparency requirements For CCOs not using OPDP: • CCO PBM contracts shall incorporate all elements directed by OHA and satisfy all requirements established by OHA including providing pharmacy cost passthrough at 100% and passback 100% of rebates	New PBM Transparency Rule 410-141-XXXX or 410-141-3390 Transparency

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	received by PBM to CCO • OHA will reserve the right to view or audit the CCO's PBM contract to verify that the pass-through requirements are met. • CCOs will ensure PBMs will demonstrate financial and organizational accountability and transparency. This includes but is not limited to providing the CCO and OHA access to public financial statements upon request and direct access to officers of the company with knowledge about strategic, financial, and operational relationships and business transactions that may directly or indirectly affect the servicing of the CCO ~~contract~~Contract. With respect to transparency, CCOs will ensure contracted PBMs fully, clearly, completely, and adequately disclose to CCO and OHA the Services it provides and all forms of income, compensation, or other remuneration it receives or pays or expects to receive or pay under contract with the CCO. • OHA will require third party market checks and audits to ensure transparency and market competitiveness is monitored. The contract template spells out requirements for the market checks and how they should be used. • CCOs will ensure contracted PBMs provides executed contract and amendments that include confidentiality agreements with any third parties who perform work under the master contract.	
OHPB #15 (COST): Address increasing pharmacy costs and the impact of high-cost and new medications by: increasing alignment of FFS and CCO PDLs	CCOs will work with OHA to identify opportunities for PDL alignment. CCOs shall adopt preferred agents identified by the P&T Committee as directed by OHA CCOs will submit PDLs for all classes to OHA in format required by OHA. CCO will be required to post PDL detains in a publicly accessible fashion and to update postings prior to or concurrent with changes made. CCOs will submit coverage criteria for all non-aligned PDL classes in format required by OHA. CCO will be required to post PDL detains in a publicly accessible fashion and to update postings prior to or concurrent with changes made.	410-141-3070 Preferred Drug List

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OHPB #16 (COST): Enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency	CCOs will use NAIC financial reporting templates as required by OHA and conform with specific OHA requirements to use Supplemental CCO-specific schedules CCOs will submit quarterly financial reports and a quarterly estimation of Reserve levels to ensure financial protections are in place during the year CCOs will submit pro-forma projections on an NAIC and RBC basis. CCOs will take necessary steps to be able to file NAIC Orange Blanks, including becoming NAIC members if necessary, and will supply OHA with supplemental data requirements.	410-141-3345 - Delete (4) and (5) referencing three alternative methods of financial reporting and solvency. All CCOs will be subject to the reporting method described in (4) (b). 410-141-3350 - Delete (1) and (7) (d), (f) and (g). Review definitions of assets, liabilities and reserves and update as necessary based on current DCBS/NAIC requirements. 410-141-3355 - Delete (1). This section will apply to all CCOs. (8) Delete reference to "Converting CCO". 410-141-3360 - Delete (1). This section will apply to all CCOs. Revise to reference 200% as the minimum RBC threshold. 410-141-3365 - Delete (1). This section will apply to all CCOs.
OHPB #30 (COST): Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts	CCOs may be subject to possible ~~sanctions~~Sanctions for failure to achieve required spending targets. Sanctions may include ~~suspension~~Suspension of auto-enrollments and financial ~~sanctions~~Sanctions in future years.	Note-New rule 410-141-3259 Sanctions becomes effective 1/1/19.
OHPB #31 (COST): Institute a validation study that samples CCO ~~encounter data~~Encounter	The submission requirement for CCO ~~encounter data~~Encounter Data will change from 180-days to 45-days;	410-141-3430 Coordinated Care Organization Encounter Claims Data Reporting

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Data and reviews against ~~provider~~Provider charts for accuracy (AZ Model) with financial implications	Certain circumstances will require that a CCO forfeits the 1% withhold for ~~encounter data~~Encounter Data submission; CCOs will retain all liability for certifying ~~encounter data~~Encounter Data as complete, truthful, and accurate; CCOs will adjust claims to reflect the final paid amount when a ~~recoupment~~Recoupment is made within 30 days of identifying an ~~overpayment~~Overpayment; CCOs will report on ~~overpayment~~Overpayment recoveries to a level of specificity required by OHA in their quarterly and annual financial reporting.	

C. Health Information Technology

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #32 (BH): Require CCOs support EHR adoption across behavioral, oral and physical health contracted ~~providers~~Providers	CCO will support the adoption of ~~electronic health records~~Electronic Health Records (EHRs) by its contracted ~~providers~~Providers, including physical, behavioral, and oral health ~~providers~~Providers. CCO will determine current rates of EHR adoption for physical, behavioral, and oral health ~~providers~~Providers CCO will set targets for increasing rates of EHR adoption among its contracted physical, behavioral, and oral health ~~providers~~Providers CCO will work with contracted physical, behavioral, and oral health ~~providers~~Providers to remove barriers to EHR adoption	Revise OAR 410-141-3180 (6) to read: (6) MCEs shall support the adoption of ~~electronic health records~~Electronic Health Records (EHRs) by its ~~provider network~~Provider Network, including physical, behavioral, and oral health ~~providers~~Providers. To achieve increased EHR adoption rates, MCEs shall: (a) Identify EHR adoption rates, divided by ~~provider~~Provider type (including physical, behavioral, and oral health ~~providers~~Providers) and geographic ~~region;~~ Region; (b) Develop and implement

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
		strategies to increase adoption rates of EHRs for physical, behavioral, and oral health ~~providers~~Providers; (c) Support EHR adoption by physical, behavioral, and oral health ~~providers~~Providers.
OHPB #33 (BH): Require CCOs ensure behavioral, oral and physical health contracted ~~providers~~Providers have access to health information exchange technology that enables sharing patient information for ~~care coordination~~Care Coordination, including timely ~~hospital~~Hospital event notifications, and require CCOs use ~~hospital~~Hospital event notifications	CCO will support access to electronic health information exchange (HIE) for ~~care coordination~~Care Coordination for contracted physical, behavioral, and oral ~~providers~~health Providers, including ~~hospital~~Hospital event notifications. CCO will determine current rates of access to/use of HIE for ~~care coordination~~Care Coordination, including timely ~~hospital~~Hospital event notifications, for physical, behavioral, and oral health ~~providers~~Providers CCO will set targets for increasing rates of access to HIE for ~~care coordination~~Care Coordination among its contracted physical, behavioral, and oral health ~~providers~~Providers CCO will work with contracted physical, behavioral, and oral health ~~providers~~Providers to remove barriers to access to HIE for ~~care~~Care ~~coordination~~Coordination CCO will ensure that contracted ~~providers~~Providers have timely access to ~~hospital~~Hospital event notifications CCO will use ~~hospital~~Hospital event notifications to inform its own ~~care coordination~~Care Coordination and population health work	Revise OAR 410-141-3180 (7)-(9). Eliminate (9), revise (7)-(8) as follows: (7) MCEs shall support access to electronic health information exchange (HIE) for ~~care coordination~~Care Coordination for contracted physical, behavioral, and oral health ~~providers~~Providers. To achieve improved HIE access rates, MCEs shall: (a) Identify current adoption rates of HIE for ~~care coordination~~Care Coordination and ~~hospital~~Hospital event notifications, divided by ~~provider~~Provider type (including physical, behavioral, and oral health ~~providers~~Providers) and geographic ~~region~~Region; (b) Ensure that contracted physical, behavioral, and oral ~~providers~~Providers have access to timely ~~hospital~~Hospital

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
		event notifications; (c) Develop and implement strategies to increase access to HIE for ~~care coordination~~Care Coordination for contracted physical, behavioral, and oral health ~~providers~~Providers; (d) Support access to HIE for ~~care coordination~~Care Coordination for contracted physical, behavioral, and oral health ~~providers~~Providers. (8) MCES shall use ~~hospital~~Hospital event notifications to support their ~~care coordination~~Care Coordination and population health efforts.
OHPB #34 (VBP/HIT): Require CCOs to demonstrate necessary information technology infrastructure for supporting VBP arrangements, including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted ~~providers~~Providers, and support contracted providers so they can effectively participate in VBP arrangements.	CCOs will maintain the health information technology (HIT) necessary to meet specified needs: o Administer ~~value-based payment~~Value-Based Payment arrangements, for example, by calculating metrics at the ~~provider~~Provider level and making payments consistent with the VBP model(s) being used; o Support contracted ~~providers~~Providers so they can effectively participate in the VBP arrangement, for example, by providing CCO claims or cost data and information on ~~provider~~Provider performance on VBP metrics and which patients are attributed to the ~~provider~~Provider; and o Manage population health efforts, for example, by risk stratifying populations and targeting interventions.	Revise 410-141-3015 (26) as follows: Each CCO has obligations related to health information technology (HIT). Applicants shall: (a) Describe any anticipated obstacles to signing a memorandum of agreement with Oregon's HIT Commons; (b) Describe how they will support increased rates of EHR adoption among contracted physical, behavioral, and oral health ~~providers~~Providers,

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	CCOs will attest that they have or will have by the start of Year 1 (2020) the health IT needed to administer their Year 1 VBP arrangements, to support contracted ~~providers~~Providers, and to manage population health efforts. CCOs will further be required to provide supporting detail about how they meet these components and their roadmaps for further development. CCOs will need to obtain OHA approval of their roadmaps. OHA may ask for further detail, including an interview or demonstration, as part of OHA's review process. CCOs will be required to report annually on progress on their roadmaps and any needed adjustments to the roadmap. OHA will further monitor CCOs' progress through the annual VBP interview. OAR 410-141-3120 contains a reference to the Oregon Common Credentialing Program, which has been suspended indefinitely. OHA plans to remove references to the Oregon Common Credentialing Program from administrative rules.	including barriers they expect those ~~providers~~Providers will face and plans for setting targets and collecting data on support efforts; (c) Describe how they will ensure that contracted physical, behavioral, and oral health ~~providers~~Providers have access to timely ~~hospital~~Hospital event notifications, including plans for setting targets and collecting data on efforts; (d) Describe how they will support contracted physical, behavioral, and oral health ~~providers~~Providers' access to health information exchange for ~~care coordination~~Care Coordination, including plans for setting targets and collecting data on efforts; (e) Describe how they will use ~~hospital~~Hospital event notifications within their own organizations; (f) Describe how they will use HIT to administer ~~value-based payment~~Value-Based Payment arrangements.

D. Social Determinants of Health

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #1 (SDOH-HE): Implement HB 4018: Require CCOs to spend portion of savings on SDOH-HE, population health policy and systems change, and health equity/health disparities, consistent with the CCO ~~community~~Community health improvement plan (CHP) and Transformation and Quality Strategy a) Require CCOs to hold contracts or other formal agreements with and direct a portion of required SDOH-HE spending to SDOH-HE partners through a transparent process b) Require CCOs to designate role for CAC in directing and tracking/reviewing spending. c) **Years 1 & 2:** Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the ~~global budget~~Global Budget rate methodology and will seek to build in a specific amount of SDOH-HE investment intended to advance CCOs' efforts to address their ~~members~~Members' SDOH-HE and establish their internal infrastructure and processes for ongoing reinvestment of a	Define SDOH-HE Partners and other terms as needed.	141-3000 Add definition of SDOH-HE Partners; SDOH; HE; health disparities; population health policy and systems change
	Define Transformation Plan to change to current Transformation Quality Strategy (TQS)	Proposed New SDOH-HE Engagement rule with section dedicated to spending and agreements/contracts with SDOH-HE partners
	CCOs will submit SDOH-HE partner MOUs or agreements to OHA for approval no later than 30 days after an agreement is executed and all MOUs or agreements for current year required spending by April 30 of each year, beginning 2021.	
	Core elements of the MOUs or agreements will include: a. Contract term b. Legal names for entities c. Any relationship or financial interest between SDOH-HE partner and CCO (i.e. ownership, governance board or CAC membership) d. Domain of SDOH-HE targeted e. Type of SDOH-HE partner (from listed categories in definition). If partner does not qualify as one of the listed categories, CCOs must submit justification for approval. f. Description and scope of project including: i. Services provided by SDOH-HE partner ii. Targeted population (i.e. #~~members/community~~Members/Community members) iii. Will the CCO identify and refer ~~members~~Members as needed? (if relevant) iv. Area/~~region~~Region covered g. How will success be evaluated/measured? h. Fund distribution method	

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portion of net income and reserves in social determinants of health and health equity. **Require one statewide priority** – housing-related supports and services – in addition to ~~community~~Community priority(ies)	i. Reporting and data collection, including i. How often are reports due? ii. What data points are collected? iii. How will you track people served in the intervention?	
	Spending will be required on health disparities and the social determinants of health (including supportive population health policy and systems change.) The definitions in the rules will reflect this to clarify that population health policy and systems change work that is supportive of social determinants of health and health equity efforts will qualify under the definition of social determinants of health. (e.g. tobacco free housing policies that support efforts to connect ~~members~~Members with safe, affordable housing)	
	CCOs must spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health. A "portion" in rule to be defined as the greater of: • % of adjusted net income on a sliding scale according to % RBC (% RBC floor and scale to be set to ensure solvency and meaningful tiers). OHA has the discretion to review medical and administrative expenses for reasonableness when assessing and determining adjusted net income. –OR – • Amount sent in dividends and/or payments to shareholders/parents/owners – OR – • An amount taken from excess reserves at the discretion of the CCO, where excess reserves is defined as reserves that meet financial requirements for restricted reserves and where once funds are removed a CCO's RBC remains at x% or above (% RBC to be established to ensure solvency).	
	CCOs must select ~~community~~Community spending priority(ies) from their current Community Health Improvement Plan (CHP) or if the plan is not yet developed from an assessment of CCO, ~~hospital~~Hospital, Local Public Health Authority, and other Community Health Improvement Plans in the ~~service area~~Service Area. Priorities identified from the CHP may be selected either from priority SDOH-HE categories (see definition) or from priority populations with health disparities and SDOH-HE challenges.	141-3145 CHA and CHPs. 141-3150 HRS Rule. Add alignment language.
	Spending priorities must be aligned with the CCOs Transformation Quality Strategy (TQS).	
	CCOs will submit SDOH-HE spending priorities to OHA for approval March 15 of 2020, and by January 2 of 2021 and each year following.	

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	CCOs will submit to OHA by April 30 a full proposal of how CCO intends to direct its SDOH-HE spending, including all components required by the ~~contract~~Contract.	
	CCOs shall report health disparities and SDOH-HE expenditures to OHA in reporting format as required by OHA.	
	CCOs shall provide narrative reporting of the project/initiative for spending description(s), services provided, outcomes and impact of spending, estimated ~~members/community~~Members/Community members impacted, SDOH-HE partners engaged in the work (including nature of partnership, whether contract, MOU, etc.) as part of the TQS reporting beginning 2021	
	Narrative reporting and financial reporting on expenditures will be posted publicly.	
OHBP #2 (SDOH-HE): Increase strategic spending by CCOs on ~~health-related services~~Health-Related Services by: a) Requiring HRS ~~community~~Community benefit initiatives to align with ~~community~~Community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and b) Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how ~~community~~Community benefit	CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on SDOH-HE and Health-~~related services community~~Related Services Community benefit initiatives.* Current CAC members (e.g. SDOH-HE Partner members) seeking funding must recuse selves from decision-making process and vote.	New SDOH-HE rule, 141-3120(1)Operations and Provisions of Health Services – expand obligations of CACs to direct, monitor and review spending
	CCOs shall align ~~community~~Community benefit initiatives with ~~community~~Community priorities from ~~community~~Community health improvement plans (CHPs). CCOs shall align with a designated statewide priority for ~~community~~Community benefit initiative investments as required by the agency.	141-3150 HRS Rule
	HRS policies will be submitted to OHA for review. Mandatory elements include descriptions of; how decisions are made, including types of eligible entities, how entities apply, how funding will be awarded, processes to capture ~~community~~Community benefit initiatives and health information technology expenditures, process to align ~~health-related services~~Health-Related Services investments with CHP priorities, and role for CAC in investment decisions.	141-3150 HRS Rule
	CCOs shall report annually all HRS spending itemized with any evidence of return on investment	141-3200 Outcomes and Quality Measures (7)

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHBP #4 (SDOH-HE): Strengthen ~~community advisory council~~Community Advisory Council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers through the following: a) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid ~~members~~Members in their communities, including: 1) How the CCO defines their ~~member~~Member demographics and diversity, 2) The data sources they use to inform CAC alignment with these demographics, 3) Their intent and justification for their CAC makeup, 4) An explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress, 5) The percentage of CAC comprised of OHP consumers, b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) and, c) Require CCOs have two CAC representatives, at least one being an OHP consumer,	CCOs shall report to OHA annually on: • CAC membership demographics, and how they use demographic and ~~member~~Member data to align CAC membership with member composition. • barriers to and efforts to increase demographic alignment and how progress will be demonstrated. This will include explanations about how individual CCOs define their ~~member~~Member demographics and diversity. • CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) • The CAC's role in decision-making on HRS, SDOH-HE spending, and other ~~community~~Community-based initiatives	New Rule 410-141-SDOH-HE 1 and 410-141-3120 Operations and Provision of Health Services
	CCOs shall demonstrate in their annual CAC report how they are updating CAC recruitment strategies, and demonstrate how the CCO has taken steps to address identified challenges, etc.	
	CAC reports shall be posted publicly to the OHA website, with demographics information redacted.	
	CCOs shall have two CAC representatives, at least one being an OHP consumer, on CCO board. CAC/consumer representatives may not have a relationship, financial or otherwise, with the CCO (e.g. current/former employee, relative of current CCO staff, other financial interest with CCO.)	141-3120(1)Operations and Provisions of Health Services
	CCOs shall develop and maintain job descriptions for CAC coordinator	Remaining issues in new SDOH-HE Engagement Rule

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
on CCO board. d) OHA is exploring adding a recommendation that CCOs use a Tribal Advisory Committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. e) OHA is exploring implementation options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, "Tribal Engagement and Collaboration Protocol." This is also occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes.		
OHPB #5 (SDOH-HE): Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following: a) Require CCOs to adopt a Health Equity plan, including culturally and linguistically	CCOs must develop Health Equity Plans at a schedule tbd for review by OHA. The plan shall include culturally and linguistically responsive practices to institutionalize the CCO's organizational commitment to Health Equity. OHA will provide feedback and technical assistance as needed. Following Year 1-CCOs will submit HE plans in March as part of the overall TQS submission process.	141-3015(8) and (24) Certification Criteria for CCOs
	OHA will address deficiencies in HE plans as needed within the authorities granted under state and federal law to ensure compliance.	New SDOH-HE Engagement Rule

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
responsive practice, to institutionalize organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.	CCOs shall develop and deploy a cultural responsiveness and implicit bias training plan according to training criteria developed by the Cultural Competency Committee on Continuing Education (https://www.oregon.gov/oha/OEI/Pages/CCCE-HB2611-2013.aspx), which includes information relevant to Oregon's laws and administrative rules on Health Care Interpreters and Traditional Health Workers. CCOs shall include a timeline for implementation. Trainings in all required domains shall occur at a frequency determined by OHA. All CCO New Employee Orientation or Training shall incorporate fundamental areas of cultural responsiveness and implicit bias and the use of healthcare interpreters. CCOs shall submit an annual training plan to OHA that includes goals, objectives, deliverables, measurements, a report of training events, and evaluation.	New SDOH-HE Engagement Rule 410-141-3120 Operations and Provision of Health Services
	CCOs shall ensure that all staff and leadership have been trained on core competencies such as; culturally and linguistically competent approach to working with consumers; CLAS standards; Health Literacy and Plain language; Civil rights laws/Title VI/ADA and unconscious bias.	410-141-3120 Operations and Provision of Health Services
	All CCO staff must receive mandatory implicit bias training. CCOs must ensure network ~~providers~~Providers receive implicit bias training, whether directly by the CCO or through ~~provider~~Provider training programs. Provider training programs must align with training criteria developed by the Cultural Competency Committee on Continuing Education.	
	CCOs shall ensure that network ~~providers~~Providers have trainings in the following core competency areas – whether provided by the CCO or through ~~provider~~Provider training programs: use of interpreters (including information relevant to Oregon's laws on Healthcare Interpreters) and ~~culturally responsive~~Culturally Responsive health care (including unconscious bias).	141-3120 Operations and Provision of Health Services for training requirements 410-141-3220 Accessibility
	CCOs shall ensure that all new staff receive required trainings at time of hire and orientation and not wait until annual training cycle.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	OHA will provide a list of approved training curriculums for CCO consideration and adoption or approve individual curriculums and trainings as needed.	
	CCOs will have a single point of accountability with budgetary decision-making authority and health equity expertise.	
	CCOs will maintain sufficient internal infrastructure and investments to coordinate and support health equity activities.	
OHPB #6 (SDOH-HE): Implement recommendations of the THW Commission: a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW ~~affiliated~~Affiliated with organizations listed under ORS 414.629 (Note that d. is also included under Policy Option 8 for CHAs/CHPs) Require CCOs to incorporate various payment strategies to establish sustainable payment rates for ~~traditional health workers~~Traditional Health Workers (THW) services.	CCOs shall create THW integration and utilization plans. The plans shall include; information about current THW usage, measurement standards, and evaluation based on benchmarks, milestones, and other outcomes. OHA reserves the right to require standardized metrics and specifications.	410-141-3220 Accessibility
	CCO shall collect data on THW integration and utilization and report to OHA using a required template.	
	THW Integration and utilization plans shall be submitted to OHA for evaluation to ensure adequacy on a basis tbd (annually or semi-annually)	
	CCOs shall adopt and customize THW integration and utilization training materials in consultation with the THW Commission.	Remainder should go in a new THW Rule which will help increase exposure/visibility for CCOs on THW requirements and not get lost in other rules.
	CCOs shall use THW Best Practices toolkits available on OHA's website to enhance organizational capacity to; □ Contract with Community -based organizations (CBO), □ align and retain THWs workforce, □ THWs support and supervision, □ Supervision competencies,	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	□ understanding THWs ~~provider~~Provider enrollment, □ improve billing and payment procedures, □ understand benefits of integrating individual THWs, and □ understand THWs scope of practices.	
	Based on OHA and THW Commission guidelines, CCOs shall establish payment model grid, informed by recommendations of the Payment Model Committee of the THW Commission, for the THW workforce that is sustainable and published. The CCO THW payment model grid will include various payment strategies, including fee-for-service, alternative payment models such as bundled payments and per-~~member~~Member per-month payments, direct employment, and other payment strategies. Sustainable rate shall mean strategies to pay for THWs services for long term employment, as opposed to short term grants or other forms of payment that result in under pay, underemployment or unemployment for THWs workforce.	
	CCOs shall require all contracted ~~providers~~Providers to submit ~~encounter data~~Encounter Data for all THW services rendered.	
	CCOs shall designate a THW liaison as the central point of contact for THW integration. This shall be a 1.0 Full Time Employee (FTE) who will act as the hub of information and THWs, consumers, and the ~~community~~Community. This position shall address the barriers to integration and utilization of THWs and their services. This position will □ Coordinate the CCOs workforce, □ design THWs integration and utilization plan within CCOs systems, □ Provide technical assistance to THW's ~~provider~~Provider enrollment within the CCO network, □ assist in coaching system navigation for THW's Workforce and ~~members~~Members; □ Provide support with establishing THW's payments and rates, THW's utilization both in clinical setting as well as ~~community~~ Community-based setting, supervision and competencies, THW service delivery, and ~~member~~Member accessibility to THW services and the ~~community~~Community within the CCO health care system.	
	CCOs shall inform all ~~members~~Members and their ~~provider networks~~Provider Networks about the availability, scope of practice and the benefits of THW services.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #7 (SDOH-HE): Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the Community Advisory Council connects to the CCO board	CCOs shall provide a current organizational chart as part of their CAC report. Charts shall show relationships between CAC and Board, how information flows between them as well as CAC and board connection to various CCO committees. The chart should also include CAC representation on the board. Requirements for the submission include a graphic of the org chart, which indicates the relationship between entities, as well as narrative describing "cross pollination" between CCO and CAC, how often the CAC and board connect, and CEO participation on CAC	141-3015 Certification Criteria for CCOs
		141-3040 Service Area Changes
		141-3120 Operation and Provision of Health Services
OHPB #8 (SDOH-HE): Require CCOs to partner with local public health authorities, non-profit ~~hospitals~~Hospitals, and any CCO that shares a portion of its ~~service area~~Service Area to develop shared CHAs and shared CHP priorities and strategies. a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. If a federally recognized ~~tribe~~Tribe in a ~~service area~~Service Area is developing a CHA or CHP, the CCO must partner with the ~~tribe~~Tribe in developing	CCOs shall collaborate with local public health authorities, non-profit ~~hospitals~~Hospitals, any CCO that shares a portion of its services area, and any federally recognized ~~tribe~~Tribe in the ~~service area~~Service Area that is developing or already has a CHA to develop a shared CHA. At the ~~community~~Community's discretion, partners may develop more than one shared CHA to cover different aspects of partner ~~service areas~~Service Areas (e.g. county-based CHAs within a larger region). The CCO shall demonstrate collaboration on the CHA by documenting regular interaction between organizations based on a shared mission and goals, shared decision making and resources.	410-141-3145(8) Community Health Assessment and Community Health Improvement Plans
	CCOs shall collaborate with local public health authorities, non-profit ~~hospitals~~Hospitals, any CCO that shares a portion of its services area, and any federally recognized ~~tribe~~Tribe in the ~~service area~~Service Area that is developing or already has a CHP to develop shared CHP priorities and strategies. The CCO shall demonstrate collaboration on CHP priorities and strategies by documenting regular interaction between organizations based on a shared mission and goals, shared decision making and resources.	
	CCOs shall describe in the CHA and CHP how organizations that address the social determinants of health and health equity, THWs, and Tribes were involved in the development of the CHA and CHP, including a list of organizations that were involved.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
the shared CHA and shared CHP priorities and strategies described above. Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP, including THWs ~~affiliated~~Affiliated with organizations listed under ORS 414.629.	CCOs shall clearly identify in the CHP health priority goals and a method for tracking improvements on meeting goals, which may include benchmarks or targets. CCOs shall clearly identify in the CHP the strategies the CCO will implement to make improvements in health priority area. CCOs shall include process measures for each strategy, including benchmarks and targets.	Intersect any additional language as needed with new SDOH-HE Engagement rule
	CCOs shall include in the annual CHP progress report updated data on health priority and strategies, barriers to meeting goals, and steps the CCO is taking to address barriers.	
	CCOs shall comply with requirements published annually by OHA for CHAs, CHPs and progress reports, which may include reporting requirements or templates.	
	CCOs shall identify in their CHP which priorities are aligned with which priorities and strategies included in the SHIP that are being implemented within the CCO's ~~service area~~Service Area.	
	CCOs in the same ~~service area~~Service Area or any area of overlap shall collaborate to develop a shared CHA and shared CHP priories and strategies. In cases where ~~service areas~~Service Areas do not perfectly match, the number of CHAs a CCO and partners develop is left to ~~community~~Community discretion. Some communities may choose to develop a single regional CHA combining multiple counties, while others may choose to develop multiple county-level CHAs or smaller regional CHAs.	
OHPB #9 (SDOH-HE): Require CCOs to submit their Community Health Assessment to OHA	CCOs shall update and submit their CHA to OHA no less frequently than every 5 years or upon request of OHA. Specific submissions will be due June 30th of the calendar year the CHA is completed in.	

E. Behavioral Heath

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #17 (BH): Require CCOs be fully accountable for the Behavioral Health benefit of their ~~members~~Members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate ~~provider network~~Provider Network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.	CCO will manage the Behavioral Health benefit. Responsibilities include:	Certification criteria change – OAR 410-141- 3015
	○ □ Ensuring resources are sufficient to integrate Behavioral Health benefits in a way that is invisible to ~~members~~Members and ~~providers~~Providers;	• 410-141-3120 Operations and Provision of Health Services
	□ Ensuring the full Behavioral Health benefit is available to ~~members~~Members	410-141-3120 Operations and Provision of Health Services
	□ Ensure ~~members~~Members have timely access to Behavioral Health services:	410-141-3220 Accessibility
	o Urgent: Immediate	410-141-3145 add Local Plan to CHP under (9). 410-141-3220 need to add timeframes for access to BH care from 309 rules.
	o Routine: Assessment/intake within 7 days, with second appointment within 14 days and 4 appointments within 48 days	410-141-3220 Accessibility
	o Pregnant women: Assessment/intake Immediately	410-141-3220 Accessibility
	□ If no capacity to accommodate them, ~~members~~Members should receive interim services within 72 hours of being put on a waitlist. Interim services should be equivalent to the appropriate level of care and may include: waitlists, ~~referrals~~Referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for SUD, risk reduction, residential services for SUD, withdrawal management, and ~~assessments~~Assessments	410-141-3220 Accessibility
	o IV drug users: Assessment/intake Immediately; Opioid use disorder: Assessment/intake 72 hours	410-141-3220 Accessibility
	o Veterans and their families: Assessment/intake immediately	410-141-3220 Accessibility

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	o **Medication Assisted Treatment (MAT): No more than 72 hours for ~~assessment~~Assessment* and induction, with efforts to do such as soon as possible.** CCO / ~~provider~~Provider must support ~~member~~Member in system navigation to receive support within the 72 hour timeframe and must utilize other ~~community~~Community resources (i.e. ~~hospitals~~Hospitals, Peer Support Specialist etc.), as needed, to do such.** If a ~~member~~Member is unable to access services within the timeline, the CCO will provide documentation regarding barriers to treatment access, as well as the active and continued efforts made to remove those barriers. CCOs will ensure that all ~~providers~~Providers offer daily engagement services while barriers to medicine are addressed. These daily services may be part of a larger ~~provider network~~Provider Network (i.e. Peer supports, ~~hospital~~Hospital usage, support groups) or may be offered within a specific ~~provider~~Provider setting.	410-141-3220 Accessibility
	o *This ~~assessment~~Assessment should include a full physical and biopsychosocial-spiritual ~~assessment~~Assessment. The method of delivery of that medication should be done taking into consideration patient circumstances, presentation and potential risks/harms. **CCO/Provider cannot require a detox protocol as a reason for denial of ~~assessment~~Assessment/induction.**	
	o **If CCO is experiencing barriers to timely access standards s, CCO must report barriers and create strategic plans to improve issues meeting this. CCO may utilize TA support to assist in this from OHA. CCOs must understand the nature of addiction, particularly opioid addiction, involves exponentially increased risk for the ~~member~~Member the longer he/she/they have to wait for services.	410-141-3220 Accessibility
	o **Engagement/Follow Up:** Patients should have no less than 2 follow up appointments within 1 week post induction and ~~assessment~~Assessment.	410-141-3220 Accessibility 410-141-3160 Integration and ~~Care~~ Coordination 410-141-3170 Intensive Care Coordination Services/Exceptional Needs Care Coordination
	o To ensure accountability, OHA will review claims data that indicates services accessed later than 72 hours and review ~~member~~Member records to review active efforts made.	410-141-3220 Accessibility 410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination Services/Exceptional Needs

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
		Care Coordination
	☐ Ensure membersMembers have access to a full range of Behavioral Health treatment and recovery options. If services are not available in the regionRegion, the CCO will continue to be responsible for the memberMember's Behavioral Health benefit while the memberMember is receiving services out of regionRegion, including care coordinationCare Coordination services.	410-141-3220 Accessibility
	☐ Ensure all providersProviders are including provision of trauma informedTrauma Informed services;	410-141-3220 Accessibility
	☐ Developing and maintaining policies and procedures for the behavioral healthBehavioral Health benefit for their entire regionRegion; *submit annually to OHA for review and approval.*	410-141-3120 Operations and Provision of Health Services
	☐ Budget managed in a fully integrated way;	410-141-3120 Operations and Provision of Health Services
	☐ Submission of a plan for annual evaluation of behavioral healthBehavioral Health spend and risk sharing;	410-141-3120 Operations and Provision of Health Services
	☐ Ensuring behavioral healthBehavioral Health services are paid for in primary care and primary care is paid for in behavioral healthBehavioral Health, without pre-authorization;	410-141-3120 Operations and Provision of Health Services
	☐ Multiple services are allowed within the same day at the same clinic	410-141-3120 Operations and Provision of Health Services
OHPB #18 (BH): Identify metrics to track milestones of behavioral healthBehavioral Health (BH) and oral health (OH) integration with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress ☐ OHA to refine definitions of BH and OH integration and add to the CCO contractContract	Revise definition of integration.	Contract Award criteria change (OAR 410-141-3015)
	CCOs will integrate physical health, behavioral healthBehavioral Health and oral health care and will meet the following performance expectations beginning in CY 2020. Beginning in CY 2021, CCOs report on OHA identified oral health integration metrics at a frequency to be determined by OHA.	410-141-3200 Outcomes and Quality Measures
	☐ CCOs will report on cost and utilization of behavioral healthBehavioral Health services, as defined by OHA.	**410-141-3200 Outcomes and Quality Measures**
	☐ CCOs will ensure that membersMembers have timely access to behavioral healthBehavioral Health services	410-141-3220 Outcomes and Quality Measures
	☐ CCOs will report on the percentage of their membersMembers receiving behavioral healthBehavioral Health services.	410-141-3200 Outcomes and Quality Measures

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
□ Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics	□ CCOs will complete comprehensive screening of mental health, substance use disorder and physical health care using evidence based screening tools. CCOs will report to OHA how they are ensuring comprehensive screenings are occurring in physical and ~~behavioral health~~Behavioral Health settings.	410-141-3200 and potential adoption of new rules for oral health
	□ CCOs will develop policies and procedures, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, for ~~prior authorizations~~Prior Authorizations. CCOs will monitor ~~prior authorizations~~Prior Authorizations and will be accountable for approvals and denials. CCOs will not require ~~prior authorization~~Prior Authorization for outpatient ~~behavioral health~~Behavioral Health services or Peer-Delivered Services. Any required ~~prior authorization~~Prior Authorization for hospitalization and residential must be approved within 3 days for adults. Any required ~~prior authorization~~Prior Authorization for residential for children must be approved within three days. The length of authorization must be based on medical necessity. CCOs will report to OHA annually on the percentage of ~~prior authorizations~~Prior Authorizations that are approved.	410-141-3200 Outcomes and Quality Measures
	~~• XXOσ ωιλλ ενσυρε σταφφ ανδ συβχοντραχτορσ αρε τραινεδ ιν ρεχοσνιζινγ πριν χιπλεσ, μοτιωατιοναλ ιντερωιεωινγ, ιντεγρατιον ανδ Φουνδατιονσ οφ Τραυμα Ινφορμεδ Χαρε ηττπσ://τραυμαινφορμεδορεγον.οργ/τιχ_ιντρο_τραινινγ_μοδυλεσ/. XXOσ ωιλλ ρεπορτ ον ωηιχη τραινινγσ αρε βεινγ ρεθυιρεδ ανδ τηε νυμβερ οφ σταφφ τραινεδ.~~ · CCOs will ensure staff and Subcontractors are trained in recovery principles, motivational interviewing, integration and Foundations of Trauma Informed Care https://traumainformedoregon.org/tic-intro-training-modules/. CCOs will report on which trainings are being required and the number of staff trained.	410-141-3120 Operations and Provision of Health Services
	□Integration Definition: Creating a system that seeks to break down barriers among and collaborate with physical, behavioral, oral, and social health care ~~providers~~Providers to put patients at the center of comprehensive, cost-effective care that improves patient experience, population health, and individual health outcomes. CCOs will ensure ~~providers~~Providers integrate ~~behavioral health~~Behavioral Health services and physical health services.	410-141-3120 Operations and Provision of Health Services
	□ CCOs will integrate funding for physical and ~~behavioral health~~Behavioral Health.	410-141-3120 Operations and Provision of Health Services

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	□ CCOs will recognize OHA's licensing standards for mental health and substance use disorder services as the minimum necessary requirements to enter the network	410-141-3120 Operations and Provision of Health Services
	□ CCOs will contract for ~~behavioral health~~Behavioral Health services with any primary care practice they contract with for physical health, which has a qualified ~~behavioral health provider~~Behavioral Health Provider.	410-141-3120 Operations and Provision of Health Services
	□ CCOs will contract for physical health services with any ~~behavioral health provider~~Behavioral Health Provider they contract with, which has a qualified physical health ~~provider~~Provider.	410-141-3120 Operations and Provision of Health Services
	CCOs will report on OHA identified ~~behavioral health~~Behavioral Health integration performance standards and expectations on a at a frequency to be determine by OHA.	410-141-3120 Operations and Provision of Health Services
OHPB #19 (BH): CCOs identify actions for the development of the medical, behavioral and oral health workforce. CCOs will: □ Report on the capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and ~~provider network~~Provider Network. CCOs must monitor their ~~provider network~~Provider Network to ensure parity with their membership. □ Develop the healthcare workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training;	□ CCOs will report on ~~members~~Members in their respective networks, the diversity and capacity of the workforce in their ~~region~~Region, and the plan to meet the need of their ~~members~~Members, including the capacity to provide needed services in a ~~culturally responsive~~Culturally Responsive, linguistically appropriate and ~~trauma informed~~Trauma Informed manner with attention to marginalized populations. This report must be submitted annually to OHA.	Amend OAR 410-141-3015 (14) to add: (j) report on capacity and diversity of the medical, behavioral, and oral health workforce within their geographical area and ~~provider network~~Provider Network.
	o CCOs will report on physical, behavioral and oral health needs in their ~~region~~Region and begin working within their local communities with local and state educational resources to develop an action plan to ensure the workforce is prepared to provide physical, behavioral and oral health services to the population. CCOs will update these plans on an annual basis and identify how they are implementing them.	410-141-3120 Operations and Provision of Health Services 410-141-3220 Accessibility
	o If a report does not identify appropriate efforts to support workforce development and network adequacy needs, it will be denied by OHA. The CCO will have 90 days to submit an updated report, incorporating relevant feedback and plans to support workforce and network adequacy needs.	Behavioral Health Rules 309-019, 018, 022 and 035 personnel training sections to require cultural competency training.
	□ OHA will develop relevant reports on workforce capacity and diversity and will make data available to CCOs.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
□ Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, ~~trauma informed~~Trauma Informed practices, with attention to marginalized populations; and Ensure current workforce completes a cultural responsiveness training in accordance with HB 2611.		
OHPB #20 (BH): Require CCOs utilize best practices to ~~outreach~~Outreach to culturally specific populations, including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)	~~CCOs~~COs will use best practices standards developed by OHA to ~~outreach~~Outreach to culturally specific populations experiencing gaps in care. CCOs will provide culturally and linguistically appropriate services to diverse populations using identified best practices.	410-141-3015(15) add "utilize best practices to ~~outreach~~Outreach to culturally specific populations"
		Yes, added to 15
	CCOs will submit a workplan with baselines, milestones and a timeline in CY 2020. In CY 2021 and ongoing, CCOs will report annually on the progress of the workplan, including milestones.	
OHPB #21 (BH): **Prioritize access for pregnant women and children ages birth through five years** to health services, developmental services, ~~early intervention~~Early Intervention, targeted supportive services, and ~~behavioral health~~Behavioral Health treatment.	CCOs will prioritize access for pregnant women, unpaid caregivers, families and children ages birth through five years to health services, developmental services, ~~early intervention~~Early Intervention, targeted supportive services, and ~~behavioral health~~Behavioral Health treatment. Pregnant women and women with children must have immediate access to ~~behavioral health~~Behavioral Health services per OAR XXX. If no capacity to accommodate them, they should receive interim services within 72 hours of being put on a waitlist.	410-141-3120 Operations and Provision of Health Services 410-141-3220 Accessibility
		OARs 410-414-3220 Accessibility and 410-414-3160 Integration and Care Coordination

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
□ CCOs will ensure access to evidenced based didactic treatment and treatment that allows children to remain placed with their primary parent. □ CCOs will support ~~providers~~Providers in assessing for ACES and trauma, to develop individual services and support plans. □ For pregnant women, CCOs will support ~~providers~~Providers in screening for ~~behavioral health~~Behavioral Health needs and substance use prenatally and post-partum. CCOs will provide appropriate ~~referrals~~Referrals and follow-up to ~~referral~~Referral. □ CCOs will prioritize access to SUD services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and ~~behavioral health~~Behavioral Health screening and treatment for children.	CCOs will ensure that pregnant women are screened for depression, anxiety and substance use at least once during the perinatal period. Screening should be universal and rely on validated tools. CCOs will ensure that clinical staff providing prenatal care are prepared to refer patients to appropriate ~~behavioral health~~Behavioral Health resources when indicated and systems are in place to ensure follow-up for diagnosis and treatment.	410-141-3220 Accessibility
	CCOs will "ensure access" to evidence based dyadic treatment and treatment that allows children to remain placed with their primary caregiver. This includes following timely access to services standards as identified in this contract and in OAR 410-141-3220.	410-141-3220 Accessibility
	CCOs will ensure that post-partum women are screened for depression, anxiety and substance use at least once during the postpartum period. Screening should be universal and rely on validated tools. CCOs will ensure that clinical staff providing post-partum care are prepared to refer patients to appropriate ~~behavioral health~~Behavioral Health resources when indicated and systems are in place to ensure follow-up for diagnosis and treatment.	Amend entry sections of 309-019 and 309-022 to update entry priority.
	CCOs will ensure that social-emotional screening for all children birth through five years is conducted in the primary care setting.	410-141-3220 Accessibility
	□ Social-emotional screening	Amend 309-019, 018, 022 and 035 to add standards for TIC to current standards for ~~assessment~~Assessment and service plan. Providers are already required to have a policy, but this could also be updated to add required components of the policy. 410-141-3220
	CCO must develop a plan to address any concerns revealed in the screening.	
	□ If ~~member~~Member meets criteria for level of care) ~~referral to behavioral health~~Referral to Behavioral Health specialist is required for further ~~assessment~~Assessment, according to timely access to service standards	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC 410-141-3220 Accessibility
	CCOs will ensure that level of care criteria for ~~behavioral health~~Behavioral Health outpatient and intensive outpatient include children ages 0-5.	Amend 309-019, 018, 022 and 035 to add standards for TIC to current standards for ~~assessment~~Assessment and

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		service plan. Providers are already required to have a policy, but this could also be updated to add required components of the policy.
	□ CCOs will ensure that children considered for the highest levels of care (day treatment, subacute or PRTS) are able to continue didactic treatment with their parents whenever possible; and have a full psychological evaluation and child psychiatric consultation	Accessibility
	□ Require that services for pregnant women and young children are trauma responsive and/or ~~trauma-informed~~Trauma Informed. Providers must be trained in ~~trauma-informed~~Trauma Informed approaches. CCOs will support ~~providers~~Providers in assessing for adverse childhood experiences and trauma in a way that is ~~culturally responsive, and trauma-informed~~Culturally Responsive, and Trauma Informed.	410-141-3220 Accessibility
	CCOs will require a minimum of intensive outpatient level of care for children 0-5 with indications of Adverse Childhood Events (ACEs) and high complexity due to one or more of the following: multi system involvement, two or more caregiver placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement	410-141-3220 Accessibility
	□ CCOs will screen for adequacy of supports to the ~~family~~Family in the home and offer supportive services as needed if they are lacking.	410-141-3220 410-141-3220 Accessibility
	□ CCOs and their contracted ~~providers~~Providers will become informed regarding the effects of adverse childhood experiences, toxic stress and structural violence and become aware of practices, tools and interventions that promote healing and resiliency in children, adults and communities	410-141-3120 Operations and Provision of Health Services
OHPB #22 (BH): Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)	All CCOs will take full risk for ~~members~~Members on OSH waitlist and share risk for ~~members~~Members in OSH by CY 2021 (e.g., CCO projects number of beds they will use, pays monthly amount to OSH based on projection, settlement at the end of the year; details of the model are in development).	141-3080 (8)(g) will be amended and implemented as follows: if the individual is enrolled in a CCO on the same day the decision is made to admit the individual to the State Hospital when a bed becomes available, the CCO shall be responsible for the ~~covered services~~Covered Services during that placement

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		even if the location of the facility is outside of the CCO's ~~service area~~Service Area. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.
		309 rules will be identified. 410-141-3066 (5) (5) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows: if the individual is enrolled in a CCO on the same day the decision is made to admit the individual to the State Hospital when a bed becomes available, the CCO shall be responsible for the ~~covered services~~Covered Services during that placement even if the location of the facility is outside of the CCO's ~~service area~~Service Area. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled. (5)(a) remove "the Authority and". Remove (5)(b) and (c). Risk sharing team to review 410-141-3160 (11)
OHPB #24 (BH): Require CCOs to ensure a ~~care coordinator~~Care Coordinator is identified for individuals with severe and persistent mental illness	Require CCOs to ensure a ~~care coordinator~~Care Coordinator is identified for individuals with SPMI, for children with SED, those in medication assisted treatment for SUD and other ~~prioritized populations~~Prioritized Populations. Additional ~~prioritized populations~~Prioritized Populations include: Pregnant Women and Women with Dependent children, IV Drug Users, Individuals with HIV/ AIDS, Individuals with Tuberculosis, Veterans and their families,	OAR 410-141-3015 Certification Criteria for CCOs

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(SPMI) and for children with serious emotional disturbances (SED), and those in medication assisted treatment for SUD and incorporate the following: □ Develop standards for ~~care coordination~~Care Coordination that reflect principles that are ~~trauma-informed and culturally responsive~~Trauma Informed and Culturally Responsive. □ Enforce ~~contract~~Contract requirement for ~~care coordination~~Care Coordination for all children in Child Welfare, state custody and other ~~prioritized populations~~Prioritized Populations (I/DD)+R[28]C Establish outcome measure tool for ~~care~~Care ~~coordination~~Coordination	individuals at the risk of First Episode Psychosis and I/DD population.	
	CCOs will complete initial screening, ~~assessment~~Assessment of exceptional health care needs and assign a ~~care coordinator~~Care Coordinator for above populations within 30 days of ~~enrollment~~Enrollment. All other populations must be assigned a ~~care coordinator~~Care Coordinator within 90 days of ~~enrollment~~Enrollment.	Revisions to 410-141-3015 to add ~~behavioral health~~Behavioral Health and requirements to ensure a ~~care coordinator~~Care Coordinator is assigned to individuals with SPMI and for children with SED
	Member reassessments: CCOs should have a process whereby ~~members~~Members are reassessed at least annually to determine whether their care plans are effectively meeting the needs of the ~~member~~Member in a person-centered, person-directed manner. Care plans should also be adjusted if a shift in responsibility is warranted or is beneficial to the ~~member~~Member.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Once these ~~assessments~~Assessments and screenings are complete, ICC ~~members~~Members will have a ~~care coordinator~~Care Coordinator assigned to them within 3 ~~business days~~Business Days. CCOs will notify ~~member~~Member of their ICC status (using at least two platforms, i.e. mail and telephone), details of this ~~care coordination~~Care Coordination program and who their assigned ~~care coordinator~~Care Coordinator no later than 5 ~~business days~~Business Days post screening and ~~assessment~~Assessment.	Relevant Rule 410-141-3170 Intensive Care Coordination (ICC) Services (Exceptional Needs Care Coordination (ENCC)) – currently states 90 days or 30 if LTS- add 30 days if SED, SPMI, Medication assisted SUD treatment
	If a ~~member~~Member is already involved in a specialized program (such as Wraparound, OYA guardianship, ACT, EASA, State Hospital, etc.), then the CCO will appoint that ~~care coordinator~~Care Coordinator of the specialized program as the ICC Care Coordinator for the ~~member~~Member, while the ~~member~~Member is in the specialized program.	
	o If a ~~member~~Member is enrolled in a specialized program during their plan period, their ~~care coordination~~Care Coordination responsibility will shift at that time.	(410-141-3160 (14) MCEs shall refer ~~members~~Members to ICC for a health ~~assessment~~Assessment within 30 days when the

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		~~member~~Member referred is receiving Medicaid LTSS or as quickly as the ~~member~~Member's health condition requires. add details on prioritized populations
	o If a ~~member~~Member is not enrolled in a specialized program, the CCO will ensure an ICC is assigned and that person will remain responsible for ~~member's care coordination~~Member's Care Coordination needs.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	o If/when a ~~member~~Member exits a specialized program, ICC responsibilities will remain under the CCO, and assignment of an appropriate ICC ~~care coordinator~~Care Coordinator must be assigned in relation to above standards (re-screening within 7 days, assignment of ICC ~~care coordinator~~Care Coordinator within 3 ~~business days~~Business Days post screening, notification to ~~member~~Member of ICC ~~care coordinator~~Care Coordinator within 5 ~~business days~~Business Days post screening).	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Members have the right to decline ~~care coordination~~Care Coordination services. CCOs to explicitly notify ~~members~~Members that their participation is voluntary and that if a ~~member~~Member declines ~~care coordination~~Care Coordination, other treatment or services cannot be denied as a result.	309 rules TBD. OAR 410-141-3160 and 410-141-3170 (Amend 309-022, and 309-035 when MH residential benefit is transferred to CCOs, to define and establish standards for ~~care coordination~~Care Coordination where applicable.)
	CCOs must re-assess for ICC needs and ensure coordination post a re-assessment trigger. Triggers are the cause. event or situation (see below). CCOs are required to track the following triggers that will cue need for earlier re-assessment of ICC needs. If a ~~member~~Member experiences a reassessment trigger, the ~~care coordinator~~Care Coordinator must complete a new ~~assessment~~Assessment of exceptional health care needs within 7 days. If a ~~member~~Member is already enrolled in ICC, the ~~care coordinator~~Care Coordinator is responsible for attempting to contact ~~member~~Member no more than 3 days post receiving notification of reassessment trigger. This must be clearly documented.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	o The following are re-assessment triggers:	

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	☐ New Hospital visit (ER or admission)	
	☐ New pregnancy diagnosis	
	☐ New chronic disease diagnosis (includes Behavioral Health)	
	☐ New BH diagnosis	
	☐ Opioid drug use	
	☐ IV drug use	
	☐ Suicide attempt, ideation or planning (identification may be through care team, diagnoses or ~~member/member~~Member/Member's care team supports.	
	☐ New I/DD diagnosis	
	☐ Priority Populations at risk for Adverse Child Experiences (ACES) (such as DHS involvement, new reports of abuse/neglect to Child Welfare Services or Adult Protective Services)	
	☐ SDOH-HE – Recent homelessness	
	☐ 2 or more billable primary Z code diagnoses within 1 month	
	☐ 2 or more caregiver placements within last 6 months	
	☐ Priority populations at risk for criminal justice involvement	
	☐ Children 0-6 who have experienced exclusionary practice (such as being asked not to return to daycare)	
	☐ School-aged children who have experienced exclusionary practice in school system (such as suspension, expulsion, seclusion, in school suspension)	
	☐ Member's child has new or ongoing ~~behavioral health~~Behavioral Health needs	
	☐ Discharge from residential setting or LTC back to ~~community~~Community	
	☐ Severe high level of self reported or detected alcohol or benzo usage while enrolled in a MAT program	
	☐ Two or more readmissions to an Acute Care Psychiatric Hospital in a six month period.	
	☐ Two or more readmissions to an ~~emergency department~~Emergency Department for psychiatric reason in a six month period	
	☐ Exit from specialized program	
	CCOs will ensure ~~care coordinators~~Care Coordinators work with ~~members~~Members to coordinate integrated care. This includes coordination of the following (as needed): physical health, ~~behavioral health~~Behavioral Health, intellectual and developmental disability and Ancillary Services.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC

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	□ CCOs must provide ~~members~~Members with flexible and creative service delivery options	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	CCOs must create a plan to ensure ~~care coordination~~Care Coordination services are ~~trauma informed and culturally responsive~~Trauma Informed and Culturally Responsive.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Children in Child Welfare, state custody and other ~~prioritized populations~~Prioritized Populations (i.e. ~~members~~Members with Intellectual/Developmental Disabilities) must receive full ICC services. CCOs will ensure children in Child Welfare, state custody and other ~~prioritized populations~~Prioritized Populations (i.e. ~~members~~Members with SPMI, SED, Intellectual/Developmental Disabilities, and juvenile justice) are assigned a ~~care coordinator~~Care Coordinator who works with the individual to complete a care plan that meets their individual needs and personal goals using best practice working with ~~prioritized populations~~Prioritized Populations. This will include dual generation work when a caregiver's Behavioral Health is impacting a child's Behavioral Health. The care plan is **expected to result in a mutually agreed upon appropriate and cost-effective planning that meets the medical, functional, social and Behavioral Health needs of the ~~member~~Member** in the most integrated setting. It should also coordinate individual ~~treatment plans~~Treatment Plans from other ~~providers~~Providers (e.g., specialty care ~~providers~~Providers) involved in the ~~members~~Members' care. Care plans may be informed by ~~community~~Community partners when necessary and upon consent of the ~~member~~Member and ~~family~~Family/caregiver. Care plans should be integrated into an individual's health record and should be reviewed and updated on an ongoing basis. Lastly, care plans should always follow the ~~member~~Member. Members shall actively participate in the creation and implementation of their care plans, unless the ~~member~~Member does not wish to participate or there is documented evidence that this would be significantly detrimental to ~~member~~Member's care or health.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Members must also be provided with a copy of their care plan at the time it is created, and after any updates or changes to the plan, unless such action is deemed to be significantly detrimental to the ~~member~~Member's care or health.	

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	If the decision is made to exclude the memberMember from this process, the assigned care coordinatorCare Coordinator must document the reasons for the exclusion, including a specific description of the risk or potential harm to the memberMember, and describe what attempts have been made to ameliorate the risk(s.) This decision must be reviewed prior to each plan update, and the decision to continue the exclusion must be documented as above.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Care plans must be developed within 10 days of enrollment in ICC program and updated every 90 days for prioritized populationsPrioritized Populations, or sooner if care plan needs change. Care plans must be developed within 30 days and updated annually for all other membersMembers not in ICC or a Specialized Program.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	The memberMember's assigned care coordinatorCare Coordinator will incorporate information from individual treatment plansTreatment Plans from other providersProviders (e.g., specialty care providersProviders) involved in the membersMembers' care. Care plans may be informed by communityCommunity partners when necessary and upon consent of the memberMember and familyFamily/caregiver. Care plans should be integrated into an individual's health record.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	In consultation with the memberMember, the care coordinatorCare Coordinator is responsible for compiling a list of Care Team members, including name, organization, contact information and role.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	CCO is responsible for ensuring that memberMember has an updated list of care team members semi-annually, or as often as Care team is updated. This list shall include names, contact information, and roles of each team member. CCO must document that memberMember has received this.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	CCOs must ensure the member's electronic health recordMember's Electronic Health Record appropriately reflects the most up-to-date information and is easily accessible to all care team members, including the memberMember.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Care coordinatorsCoordinators must actively engage the memberMember (and their caregiver when they have one) and ensure that he/she/they understand their role outlined in the care plan and feel equipped to fulfill their responsibilities.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	CCOs must implement at least 1 evidence-based outcome measure tool for care coordinationCare Coordination services (both at the PCP-managed care coordinationCare Coordination level and ICC care coordinationCare Coordination level).	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC

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	CCOs may use a variety of measurements. OHA directs CCOs to use the Medicaid Core Sets (https://www.medicaid.gov/medicaid/quality-of-care/index.html)	
	Below are some general ways that CCOs may measure for successful ~~care coordination~~Care Coordination:	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	Annual Health Assessments – Measure individual Member health over time.	
	Communication – Measure communication between Member/~~family~~Family and health care professionals, communication within teams of health care professionals, and communication across health care teams or settings. This is especially important for measuring effective transitions of care.	
	Patient Satisfaction – Members surveys can be used to identify the Member's experience as a patient and level of satisfaction in terms of coordinated care and quality of life.	
	Provider Satisfaction – Provider surveys can be used to measure ~~provider~~Provider satisfaction in terms of ~~provider~~Provider and facility coordination, communication, and whether or not the ~~providers~~Providers has the tools necessary to coordinate care (EHRs, timely ~~referral~~Referral processes).	
	Improved Outcomes and Prevention – Measure clinical and utilization related outcomes can be used to identify decreases in avoidable hospitalizations and Emergency ~~department~~Department use and increases in home and ~~community~~ Community-based services. Measurements may also be established to assess successful prevention efforts and the alignment of health outcomes between delivery system partners, including Area Agencies on Aging, the Health Authority, Local Mental Health Agencies, and Long-term Care.	
	CCOs and OHA to develop statewide standards for ~~care coordination~~Care Coordination and ICC within the first year of ~~contract~~Contract. Standards should include trauma-informed and ~~culturally responsive~~Culturally Responsive services.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	□ CCO will ensure continuous care management for all ~~members~~Members, not only those in ICC or specialized programs, through episodes of care, regardless of physical location of individual	

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	□ If ~~members~~Members need services which are out of the geographical ~~region~~Region of the CCO due to lack of local availability, the CCO will retain responsibility for the ~~member~~Member and their care. The ~~care coordinator~~Care Coordinator will work with the out of ~~region~~Region entity to ensure transition back to the home ~~region~~Region, or Home CCO, when care out of ~~region~~Region is completed. If a ~~member~~Member loses Medicaid coverage (such as through incarceration or a state ~~hospital~~Hospital level of care need) while in an episode of care, the ~~care coordinator~~Care Coordinator will continue to manage the ~~client~~Client's care until Medicaid coverage is resumes.	
	o CCO assigned ~~care coordinator~~Care Coordinator must have contact with active program-specific care team, at least twice per month, or sooner if clinically necessary for ~~member~~Member's care.	
	□ Transition Meeting Requirements	
	o CCO assigned ~~care coordinator~~Care Coordinator must participate and play an active role in discharge planning for ~~member~~Member from specialized facility.	
	For State Hospital and Residential care: Care ~~coordinator~~Coordinator shall have contact with the ~~member~~Member, who will be soon returning to Contractor's ~~region~~Region, no less than 2 times per month prior to discharge and 2 time within the week of discharge. Contractor shall make every effort to engage in a face-to-face Warm Handoff for ~~member~~Member between any ~~care coordinator~~Care Coordinator and other relevant care ~~provider~~Provider during transition of care and discharge planning. Per ICC reassessment triggers expectation, ~~care coordinators~~Care Coordinators (including ICC) shall also engage with the ~~member~~Member, face to face, within 2 days post discharge. For Acute care: Care ~~coordinator~~Coordinator shall have contact with the ~~member~~Member, who will soon be returning to Contractor's ~~region~~Region, with initial contact, face to face as possible, within 1 ~~business day~~Business Day of admission, 2 times a week while in Acute care and no less than 2 times a week within the week of discharge.	
	o CCOs will require a transition meeting and development of a transition plan that includes a description of how treatment and supports will continue. This meeting must be held prior to ~~member~~Member's return to Home CCO, 30 days prior to discharge or ASAP if notified of impending transition with less than 30 days lead time.	
	o CCOs will require a post-transition meeting of IDT team for ICC ~~members~~Members within 14 days of return to Home CCO to ensure care was continued and quickly address any gaps.	

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	□ CCO will oversee management of all ~~members~~Members who have had a lapse in Medicaid coverage, and work within the CCO/~~region~~Region to establish services which may be needed but currently are not available, in their ~~region~~Region.	
	□ Ensure applicable services continue after discharge.	
	CCOs are responsible for	New Rule 410-141-XXXX-Care Coordination Responsibilities
	1. Use of motivational interviewing and other patient-centered tools to actively engage ~~members~~Members in managing their health and well-being.	
	2. Setting of agreed upon goals for the patient with continued CCO network support for self-management goals.	
	3. Promotion of the utilization of preventive, early identification and intervention, and chronic disease management services.	
	4. Focus on prevention, and when it is not possible, effort shall be made to manage exacerbations and unanticipated events impacting progress toward designated outcomes ~~and~~.	
	Treatment interventions to address the identified condition(s)	
	1. Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual	
	2. Medication management	
	3. Intensive ~~community~~Community-based services and supports	
	Provide Peer-Delivered Services and supports	
	CCOs must offer Peer-Delivered Services and supports to all ICC ~~care coordination~~Care Coordination members.	
	Continuity of care and recovery management	
	1. Continuous care management shall occur through episodes of care, regardless of location of individual	
	2. Monitoring of conditions and ongoing recovery and stabilization shall be the goals of ~~care coordination~~Care Coordination-	
	Rescreening for ICC needs must be completed annually	
	Condition management and whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual and including avoidance and minimization of Acute events and chronic condition exacerbations	

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	4. Member/Family engagement	
	5. Transition planning, addressing the individual's goals and needs, across levels of care, providerProvider types, and service systems while addressing characteristics such as age, culture, and language, etc.	
	The CCO must ensure that care coordinatorsCare Coordinators are providing appropriate services and supports to membersMembers. Whomever within the CCO has such responsibility must be a licensed master's level mental health professional. This responsibility cannot **be delegated outside of the CCO.** The CCO will hold care coordinator providersCare Coordinator Providers responsible for ensuring integrated coordination of care. It is ultimately the CCO's responsibility to provide appropriate care coordinationCare Coordination to all membersMembers, and in particular special populations. The CCO must provide full oversight and supervision to the assigned care coordinatorsCare Coordinators.	
	The CCO will ensure:	410-141-3120 Operations and Provision of Health Services 410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	o Monthly review of no less than 75% of care coordinatorCare Coordinator's assigned memberMember cases. This will ensure above goals of care coordinationCare Coordination are not only occurring but also successful and demonstrating supportive, improvements in memberMember's health.	
	□ The case analysis review shall be conducted monthly, and shall include, at a minimum:	
	□ Consultation with the memberMember / responsible party as often as care needs indicates, with expectation that CCO will reach out to ICC memberMember when there is an Acute episode, concerns with care coordinationCare Coordination or other pressing needs expressed by the memberMember or their ICC care coordinatorCare Coordinator.	
	□ A medical record chart review of the memberMember;	
	□ Consultation with no less than 2 of the memberMember's treatment team professionals through direct contact	
	□ Review of care coordinationCare Coordination practices	
	□ Review of administrative data such as claims/encounters/service delivery; and	
	□ Demographic and customer service data.	

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	o Monitor interventions and therapies provided	
	□ Communicate with the ~~member's~~Member's assigned Care Coordinator, treatment team or other service providers to ensure management of care and services including addressing and resolving complex, difficult care situations.	
	□ Provide technical assistance to Care Coordinators including case review, continuous education, training and supervision as needed.	
	o Assess ~~member~~Member for satisfaction of services prior to ~~grievances~~Grievances .	
	□ Provide additional support to ~~member~~Member if ~~member~~Member has concern or additional need for ~~care coordination~~Care Coordination that are not met by assigned ~~care coordinator~~Care Coordinator	
	□ Manage short term care for high needs patients	
	o Oversight of Care Coordinators	
	□ At least Monthly face-to-face meetings with ~~care coordinators~~Care Coordinators to review progress and, if necessary, create improvement plans.	
	o Outreach and population management	
	CCOs will require all Care Coordinators to:	
	o **Monitor conditions, stabilization and ongoing recovery**	
	□ CCOs will utilize holistic and person-centered person approach to single or multiple chronic conditions based on the goals and needs identified by the individual. This includes CCO's efforts to avoid and minimalize Acute events and chronic condition exacerbations	
	□ CCOs will utilize tools to actively engage ~~members~~Members in managing their health and well-being, including motivational interviewing, time spent with the ~~member~~Member reviewing needs and strengths, and other patient centered tools.	
	o **Develop and monitor care plan:** Setting of agreed upon goals for the patient with continued CCO network support for self-management goals.	
	□ Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual	
	o **Promote the utilization of preventive, early identification and intervention**, and chronic disease management services.	

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	□ Focus on prevention, and earliest possible identification, and when it is not possible, effort shall be made to manage exacerbations and unanticipated events impacting progress toward designated outcomes	
	o **System Mapping and Navigation Support** –Care ~~coordinators~~Coordinators shall provide the ~~member~~Member / responsible person with education and systems navigation support. This includes help identifying and accessing resources and supports such as SSI/SSDI, vocational programs, and other ~~community~~Community programs. Care ~~coordinators~~Coordinators will also assist the ~~member~~Member with identifying and strengthening natural supports, including social and Peer support.	
	□ Care ~~coordinators~~Coordinators shall also track the ~~member~~Member's eligibility status for covered benefits and assist with eligibility applications or renewals.	
	o **Monitoring and follow up activities**	
	□ Hospital/Juvenile Justice/Corrections usage: Care ~~coordinators~~Coordinators must engage with ~~member~~Member in follow-up calls or visits within 3 days of discharge from a ~~hospital~~Hospital or OYA/Juvenile Justice/correctional facility.	
	o **Referral and related activities** (such as scheduling appointments for the individual) to help the eligible individual obtain desired services.	
	o **Provide Peer-Delivered Services and supports**	
	□ CCOs must offer Peer-Delivered Services and supports to all ICC ~~care coordination~~Care Coordination members.	
	o **Member/Family engagement**- The CCO must include the ~~member~~Member, and when appropriate, ~~family in care coordination~~Family in Care Coordination needs and care planning. The planning, development, and implementation of care plans must be directed by the ~~member~~Member / responsible person. The ~~member~~Member, and when appropriate, their ~~family~~Family, must be meaningfully engaged in the process of care planning and ~~care coordination~~Care Coordination. Ensuring that plans are driven by the ~~member~~Member and ~~member~~Member's representative is a critical piece of successful ~~care coordination~~Care Coordination.	
	o **Care ~~coordinators~~Coordinators will incorporate age, development, culture, language and other individualized characteristic**s when working with individuals to address their goals, strengths and needs across levels and episodes of care, including transition planning	
	□ Specific to ICC,	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	o **Care coordination activities include**: "(a) early identification of ~~members~~Members eligible for ICC services; (b) assistance to ensure timely access to ~~providers~~Providers and capitated services; (c) coordination with ~~providers~~Providers to ensure coordination is given to unique needs in treatment planning; (d) assistance to ~~providers~~Providers to ensure consideration is given to unique needs in treatment planning; (e) aid with coordinating necessary and appropriate linkage of ~~community~~Community support and social service systems with medical care systems"; (f) Subcontractors shall be monitored to ensure language and disability access are provided consistently across services and settings of care." (OAR 410-141-3170 (9)).	
	o Member Contact	
	□ ICC ~~care coordinators~~Care Coordinators will meet face to face with the ~~member~~Member, or make multiple documented attempts to do such, for the initial and exiting appointments.	
	□ ICC ~~care coordinators~~Care Coordinators are required to have face to face contact ~~member~~Member **individually at least every 3 months . If unable to do such, CCOs must provide documentation regarding attempts made, barriers and efforts/plans to overcome barriers.**	
	ICC Care Coordinators must have a minimum of contact, face to face where possible, 3x a month, or more frequent if clinically indicated.	410-141-3160 Integration and Care Coordination 410-141-3170 Intensive Care Coordination/ENCC
	□ The ~~care coordinator~~Care Coordinator is responsible for attempting to contact ~~member~~Member no more than3 days post receiving notification of reassessment trigger (see above/ as referenced in XXX). ICC ~~care coordinators~~Care Coordinators must continue "caring contacts" as long as deemed necessary by care team. This must be clearly documented.	
	□ Caring Contacts are defined as: brief communications with a patient that start during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a Qualified Mental Health Professional deems necessary.	
	o Care Team Contact	
	□ ICC Care ~~coordinators~~Coordinators will have **contact with PCP no less than 1 month of ICC assignment, then additionally no less than once a month to ensure integrated care, or sooner is ~~member~~Member's needs indicate.**	
	o ICC Care ~~coordinators~~Coordinators are responsible for **running interdisciplinary team (IDT) meetings monthly, or sooner**, based on need.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	ICC ~~care coordinators~~Care Coordinators shall facilitate these meetings.	
	o IDT meetings must include the ~~member~~Member / responsible person, unless the ~~member~~Member does not wish to attend or the ~~member~~Member's care team agrees that attendance would be significantly detrimental to the ~~member~~Member's care / health.	
	□ If the decision is made to exclude the ~~member~~Member from the IDT meeting, the assigned ~~care coordinator~~Care Coordinator must document the reasons for the exclusion, including a specific description of the risk or potential harm to the ~~member~~Member, and describe what attempts have been made to ameliorate the risk(s.) This decision must be reviewed prior to each meeting, and the decision to continue the exclusion must be documented as above.	
	□ Care ~~coordinators~~Coordinators must communicate among behavioral and physical health service ~~providers~~Providers regarding ~~member~~Member progress and health status, test results, lab reports, medications and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services or errors;	
	□ It is the ICC responsibility to gather feedback from PCP or arrange for someone from PCP staff to bring material to the IDT meeting	
	□ IDT meetings shall:	
	□ Describe the clinical interventions recommended to the treatment team;	
	□ Identify coordination gaps, strategies to improve ~~care coordination~~Care Coordination with the ~~member~~Member's service ~~providers~~Providers;	
	□ Require strategies to monitor ~~referrals~~Referrals and follow-up for specialty care and routine health care services including medication monitoring; and	
	□ Align with the ~~member~~Member's individual Care Plan	
	o If a ~~member~~Member is enrolled in other larger systems that appoint a care manager (i.e. I/DD System, Juvenile Justice, etc.), the ICC Care Coordinator remains responsible for the overall care of the ~~member~~Member, while the specific care manager supports specific needs based on their specialty within the IDT.	
	o No more than 15 ~~members~~Members per ICC ~~care~~Care ~~coordinator~~Coordinator	
	□ 15:1 Ratio	
	□ If ~~member~~Member is in a specialized program, CCO must follow ~~care coordination~~Care Coordination standards for that specialized group primarily. The ratio for ~~members to care coordinator~~Members to Care Coordinator will be	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	whichever is lower.	
	□ CCOs will complete a **report semiannually** that identifies ~~care coordination~~Care Coordination practices used with ~~members~~Members, overall review of ~~care coordinators~~Care Coordinators (separated by delegated out of CCO and CCO employee ~~care coordinators~~Care Coordinators), identification of any significant events that happened to ~~members~~Members, data on frequency of triggers for re-assessment exhibited within the reporting period, activity logs of ~~care coordination~~Care Coordination services, creation of plan with strategies to improve ~~care coordination~~Care Coordination with ~~member~~Member service ~~providers~~Providers, reports of ~~member/member~~Member/Member's supports ~~grievances~~Grievances related to ~~care coordination, corrective action plan~~Care Coordination, Corrective Action Plan to improve common ~~grievances~~Grievances and improve care	
	o This report is subject to ~~corrective action~~Corrective Action from OHA if OHA compliance team deems ~~care coordination~~Care Coordination requirements stated in rule ~~and/~~or ~~contract~~Contract are not being met.	
	□ CCOs will identify a plan to further the breadth and improve the overall process of ~~care coordination~~Care Coordination access for its ~~members~~Members. This plan shall also include discussion of gaps in ~~care coordination~~Care Coordination services, populations that need additional support and plans for improving the ~~care coordination~~Care Coordination system within their CCO.	
	o This plan is subject to approval by the board and must be updated semiannually with milestones and accomplishments.	
OHPB #25 (BH): Develop mechanism to assess adequate capacity of services across the continuum of care. Ensure ~~members~~Members have access to services across the continuum of care.	OHA to put mechanisms in place to ensure CCOs have adequate capacity of services across the continuum of care.	410-141-3220 Accessibility

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
OHPB #26 (BH): System of Care to be fully implemented for the children's system	1. Require CCO's to ensure a functional System of Care governance structure:	Amend 309-019 and 309-022 to add standards for cross-system collaboration. 410-141-3120
	□ Practice level work group; Filter and analyze barriers submitted by ~~community~~Community.	
	□ Advisory Council; advises policy development, financing, implementation, reviews fidelity and outcomes, and provides oversight using a shared decision-making model	
	□ Executive council; Develop and approve related policies, shared decision-making regarding funding and resource development, review of project outcomes, and identify identification of unmet needs in the ~~community~~Community to support the expansion of the service array.	
	2. CCOs will track submitted, resolved and unresolved barriers, and send to Statewide Steering committee quarterly.	
	3. Require CCO's to convene groups with representation from youth, families, DHS (Child Welfare, I/DD), special education, Juvenile Justice, OYA and mental health, youth and ~~family~~Family voice representation to be 51%.	
	4. By end of CY 2020, CCOs will have written:	
	□ Charters and new ~~member~~Member handbooks for Practice Level Work group, Advisory Council and Executive council	
	□ A System of Care Brief due annually to OHA specifying CCO commitment to upholding SOC principles, summary of local issues addressed through the SOC governance structure, data informed priorities for the following year	
OHPB #27 (BH): Require **Wraparound is available to all children and young adults who meet criteria**	1.Require CCO's to provide funding, and resources to the implementation of fidelity Wraparound by hiring and ensuring that each role is trained in Fidelity Wraparound:	Amend 309-019 and 309-022 to add standards for Wrap-around, where applicable, and to add requirement for Wraparound services policy and procedure.
	Wraparound Care Coordinators	
	Wraparound Supervisors and Coaches	
	Youth Peer Delivered Service Providers	
	Family Peer Delivered Service Providers	
	Access to flexible funding	
	2. CCO is required to screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound OARs.	
	3. Require CCOs to administer the Wraparound Fidelity Index Short Form (WFI-EZ):	
	□ For each youth and caregiver enrolled in Wraparound, once after six months of being enrolled.	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
	□ WFI-EZ Report 8: Areas for Improvement in WrapTrack to identify specific focus areas. These items should be the target of ongoing program improvement and scores should be monitored over time for progress. Report 8 to be shared with SOC Advisory Council no less than four times a year. A minimum of 35% response rate of youth enrolled is needed for statistical significance.	
	□ A minimum of 35% response rate of youth enrolled is needed for statistical significance.	
	4. CCO's are required to submit a Wraparound Policy that addresses:	
	• How Wraparound is implemented and monitored by sub-~~contractors~~contractorSubcontractors	
	• A plan for communicating WFI-EZ and other applicable data to the System of Care Advisory Council	
	• A plan for serving eligible youth in Wraparound so that no youth is placed on a waitlist.	
	5. Require CCO's to ensure that every youth in Wraparound receives a Child and Adolescent Needs and Strengths screening within 30 days of enrollment and every 90 days thereafter, per Wraparound OAR.	
OHPB #28 (BH): MOU between CMHP and CCOs enforced and honored Identify and address billing system and policy barriers to integration:	CCOs will have a written agreement with the Local Mental Health Authority in CY 2020, in accordance with ORS 414.153.	410-141-3220 Accessibility
		(OAR 410-141-3015)
	The CCOs will coordinate the development of the ~~community~~Community health improvement plan under ORS 414.627 with the local planning of the Local Mental Health Authority (ORS 430.630).	Need to add that CHP and Local Plan should be collaborative documents that inform one another
OHPB #29 (BH): • Identify and address billing system and policy barriers that prevent Behavioral Health ~~providers~~Providers from billing from a physical health setting • Develop payment methodologies to reimburse for		TBD. 410-141-3220 add Warm Handoff requirement ; Oral Health: Amend 410-3120 rules to reimburse for Warm Handoffs, consultations using appropriate CDT codes. (Amend chapter 309, divisions 019, 018 and 022 to include definitions for these three service components.)

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
Warm Handoffs, impromptu consultations and integrated care management services • Examine equality in Behavioral Health and physical health reimbursement	Warm Handoff: transfer of care between two members of the health care team, where the handoff occurs in front of the patient and ~~family~~Family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care. https://www.ahrq.gov/professionals/quality-patient-safety/patient-~~family~~Family-engagement/pfeprimarycare/interventions/warmhandoff.html	
		Development of 410-141-3160(9)
	In-home care: Behavioral Health services delivered in the ~~member~~Member's home.	
	Discharge Planning involves the transition of a patient's care from one level of care to the next or episode of care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities.	
	CCOs are required to reimburse for all services delivered in integrated clinics by qualified ~~providers~~Providers.	
OHPB #32 (BH): Require CCOs support EHR adoption across behavioral, oral and physical health contracted ~~providers~~Providers	☐ CCO will support the adoption of ~~electronic health records~~Electronic Health Records (EHRs) by its contracted ~~providers~~Providers, including physical, behavioral, and oral health ~~providers~~Providers.	
	☐ CCO will determine current rates of EHR adoption for physical, behavioral, and oral health ~~providers~~Providers	
	☐ CCO will set targets for increasing rates of EHR adoption among its contracted physical, behavioral, and oral health ~~providers~~Providers	
	☐ CCO will work with contracted physical, behavioral, and oral health ~~providers~~Providers to remove barriers to EHR adoption	
OHPB #33 (BH): Require CCOs ensure behavioral, oral and physical health contracted ~~providers~~Providers have access to health information exchange technology that enables sharing patient information for ~~care coordination~~Care	☐ CCO will support access to electronic health information exchange (HIE) for ~~care coordination~~Care Coordination for contracted physical, behavioral, and oral ~~providers~~Providers, including ~~hospital~~Hospital event notifications.	
	☐ CCO will determine current rates of access to/use of HIE for ~~care coordination~~Care Coordination, including timely ~~hospital~~Hospital event notifications, for physical, behavioral, and oral health ~~providers~~Providers	
	☐ CCO will set targets for increasing rates of access to HIE for ~~care coordination~~Care Coordination among its contracted physical, behavioral, and oral health ~~providers~~Providers	

OHPB Policy #	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
Coordination, including timely hospitalHospital event notifications, and require CCOs use hospitalHospital event notifications	□ CCO will work with contracted physical, behavioral, and oral health providersProviders to remove barriers to access to HIE for careCare coordinationCoordination	
	□ CCO will ensure that contracted providersProviders have timely access to hospitalHospital event notifications	
	□ CCO will use hospitalHospital event notifications to inform its own care coordinationCare Coordination and population health work	

F. OHA Miscellaneous Policy Options

Category	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
Subcontracts	CCOs will provide copies of subcontracts to OHA and an exhaustive list of entities and all work and services performed by a ~~subcontractor~~Subcontractor annually (or any time there has been a change in ~~subcontractor~~Subcontractor). CCO retains full responsibility for the performance of all subcontracted work.	OAR 410-141-3120 Operations and Provision of Health Services OAR 410-141-3180 Record Keeping and Use of Health Information Technology
Third Party Liability and Recovery	When a CCO is aware that a ~~member~~Member has third party insurance coverage, it must notify OHA (OPAR/TPL unit) within 30 days via the online portal or by other format as prescribed by OHA. CCOs will require that ~~providers~~Providers and ~~subcontractors~~Subcontractors report to OHA when they become aware a ~~member~~Member has other coverage. Failure to report this information that results in an ~~overpayment~~Overpayment will result in a ~~recoupment~~Recoupment and may result in a financial penalty.	OAR 410-141-3080 Disenrollment from Coordinated Care Organizations OAR 410-141-3420 Managed Care Entity (MCE) Billing OAR
Fraud, Waste, Abuse	CCOs will refer any credible allegation of ~~fraud~~Fraud to the state using the Fraud Referral Form within 10 calendar days. CCO ~~subcontractors~~Subcontractors shall abide by the same timelines and requirements. CCOs will provide a quarterly report of all ~~provider~~Provider audits conducted by the plan, using the Audit Report Template including information on any ~~overpayment~~Overpayment that was recouped and adjusting the encounter claim as necessary to reflect the recovery.	410-141-3180 Record Keeping and Use of Health Information Technology 410-141-4050 Authority to Audit Records
Grievances and Appeals	Adjudication of ~~appeals~~Appeals cannot be delegated to ~~subcontractors.~~ Subcontractors.	410-141-3230 MCE Grievance and Appeals 410-141-3235 MCE Grievance Process Requirements 410-141-3240 Notice of Action-Adverse Benefit Determination Notice Requirements 410-141-3245 MCE Appeal Requirements

Category	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
Oversight and Governance	CCOs will provide a clearly defined Organizational Structure and Chart that addresses oversight responsibility, scope of standards, etc. on an annual basis and anytime a change is made. The Organizational chart will include key positions and entities, including parent company and subsidiaries, business relationships, etc. Information about key committees with reporting and accountability structure and purpose of each committee, etc. will be included	410-141-3030 Implementation and Transition 410-141-3040 Service Area Change (SAC) for Existing Coordinated Care Organizations (CCOs) 410-141-3120 Operations and Provision of Health Services
Member Materials	CCOs are required to correct deficient enrollee materials identified by OHA through template reviews, quarterly sample NOA reviews or through Hearings. CCOs will abide by timeframes set by OHA for review and approval of ~~member~~Member materials prior to issuance to ~~members.~~ Members. If OHA identifies CCO non-compliance, CCOs will comply in a timely and complete manner including materials developed and issued by ~~subcontractors~~Subcontractors on behalf of the CCO. CCOs will correct and implement corrected materials no later than 60 days following notification from OHA.	410-141-3270 Coordinated Care Organization Marketing Requirements 410-141-3280 Managed Care Entity (MCE) Potential Member Information Requirements 410-141-3300 Managed Care Entity (MCE) Member Education and Information Requirements
External Quality Review	CCO are responsible for ensuring any ~~subcontractors~~Subcontractors fully cooperate with EQRO requests for documentation, required to address findings with improvement plans;	410-141-3120 Operations and Provision of Health Services
Subcontracts and Non-Emergency Medical Transportation (NEMT)	CCOs will report data collected in course of monitoring/oversight of CCO's own call centers and/or ~~subcontractors~~Subcontractors call centers on the following metrics; call volume, 1 call resolution, types of calls, average time, % hang-ups, etc. CCOs will provide data to OHA quarterly on NEMT performance. Data points include but are not limited to; missed rides, denied rides, complaints about rides, volume of trips, high utilization times, high utilization destinations.	OAR 410-141-3180 Record Keeping and Use of Health Information Technology 410-141-3485 (NEMT) Reports and Documentation
Program Integrity	CCOs must submit an annual audit plan for network ~~providers~~Providers to OHA and provide results of the audit to OHA using the Audit Report Template	410-141-3120 Operations and Provision of Health Services OAR 410-141-3180 Record Keeping and Use of Health Information Technology

Category	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
Network Adequacy	Removal of "~~community standard~~Community Standard" in the lesser of logic of time and distance standards for access to primary care. Replacing with less subjective, and more qualitative and quantitative requirements. (See below) Revisions to requirements that CCOs have "policies and procedures" to ensure timely and appropriate access to care, to requiring CCOs to ensure timely and appropriate access to care. Includes CCO requirements to provide certified or qualified interpreters when necessary, and systems in place to communicate with ~~members~~Members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or there is no telephone Requirement that CCOs submit access plan to OHA for approval of network adequacy. CCOs will have systems for collecting and reporting data to OHA in the following areas; • Provider to enrollee ratios • Travel time and distance to ~~providers~~Providers • Percentage of contracted ~~providers~~Providers accepting new ~~members~~Members • Wait times to appointment • Hours of operation • Call center performance and accessibility New access standards for Behavioral Health services and special populations	OAR 410-141-3220 Accessibility
Grievances and Appeals	CCOs must issue Notices of Action for Adverse Benefits Determination. (NOABDB) to its members for any and all Adverse Benefit Definitions	410-141-3230 MCE Grievance and Appeals 410-141-3235 MCE Grievance Process Requirements 410-141-3240 Notice of Action-Adverse Benefit Determination Notice Requirements 410-141-3245

Category	Rule Concept and Need	Rule Change (New or Amended) Citation and Description of Change
		MCE Appeal Requirements
Definitions	Definitions of oral health, oral health care and oral health care ~~provider~~Provider (new rules)	410-120-0000 Acronyms and Definitions
OHA/CCO Dispute Resolution	OHA right to determine situations appropriate for administrative or contested case reviews.	410-141-3267 Process for Resolving Disputes between Coordinated Care Organizations (CCOs) and the Oregon Health Authority
Service Area Changes	Revisions to reflect changes in approaches to how ~~service area~~Service Area expansion is defined.	410-141-3040 Service Area Change (SAC) for Existing CCOs
NEMT	Increased specificity of NEMT program requirements, including documentation of services and monitoring of ~~subcontractors~~Subcontractors	410-141-3435 – 410-141-3485

Document comparison by Workshare Professional on Friday, January 25, 2019 11:27:16 AM

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Description	04 CCO RFA 4690-0 Appendix C Administrative Rule Concepts Final
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