
Care Coordination

July 25, 2023



Health Systems Division

Oregon's CCO Model

- Oregon's CCO model is intended to deliver better health and better care at a lower cost.
- One important way CCOs do this is by coordinating services for their members according to the identified needs of the member.
- This is called Care Coordination, and it is intended to improve member satisfaction and health outcomes, and to reduce health inequities and barriers to care.
- Members report gaps in Care Coordination and CCOs report increased administrative complexity diverting attention from members' care.

Identifying Member Needs

- Identified on an initial basis through the Health Risk Screening or other health information shared by involved entities.
- Updated on an ongoing basis by reviewing information from the member's medical record as they interact with the healthcare system (e.g. progress notes, new diagnoses/courses of treatment/emergent needs, utilization of services).
- Member needs include health (physical, behavioral, and dental) and social needs, as well as the member's goals and preferences.

Coordination of Services

- According to a members' needs, goals, and preferences
- Accomplished by development and implementation of a Care Plan
- Comprehensive in Scope (all members, all services)
- Enabled by appropriate Infrastructure (Systems, Processes, Agreements/MOUs, Information Sharing, etc.)

When Services are Appropriately Coordinated

Members should experience:

- Knowing where to go for help and what resources are available.
- Feeling like their needs are being met.
- Clear communication from providers.
- Less duplication of screenings/assessments/etc.
- Timely access to and referrals for appropriate care.
- Person-centered and Trauma-Informed Care.
- Smooth transitions between levels of care and between CCOs/FFS.
- Engagement in the care planning process.
- Coordinated Care without having to initiate or ask for it.

New Direction

- Addresses the previously identified concerns from the CCO Learning collaborative and member feedback/complaints received through the Ombuds team.
- Ensures CCOs are meeting minimum requirements in federal Medicaid Managed Care rules and Oregon Revised Statutes.
- Aims for a clearly organized OAR structure.
- Simplifies the definition of Care Coordination to emphasize the needs of the member.
- Clarifies expectations, roles and responsibilities of CCOs.
- Shifting the focus to outcomes rather than prescriptive timeline and process.
- Provides flexibility to encourage CCOs to be innovative in the way they provide Care Coordination for their members.
- Enables OHA to have an increased focus on monitoring and oversight.

Next Steps

1. **Prior to RAC:** Provide draft rules and gather feedback from CCOs, members, and OHA staff. Interest in reconvening CCO subject matter experts to obtain feedback.
2. **Rule Advisory Committee:** Hold RAC in September 2023.
3. **Care Coordination Report:** Updates to 2024 reporting to reflect OAR changes.
4. **CCO Contract:** Updates to reflect rule changes upon adoption of the new rules. Contract includes footnotes to indicate where there may be changes.
5. **Health Risk Screening:** Updates to include additional evaluation criteria based on revised rules. Align with Health Risk Screening measure guidance.
6. **Sub-regulatory Guidance:** Develop guidance to assist with implementation.

Questions or Feedback?

Please email HSD.QualityAssurance@odhsoha.oregon.gov and include Care Coordination in the Subject Line