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# TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

## DMAP 6-2021

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

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ARCHIVES DIVISION
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& LEGISLATIVE COUNSEL

FILING CAPTION: Coordinated Care Organization (CCO) Care Coordination Reporting Requirements

EFFECTIVE DATE: 02/10/2021 THROUGH 08/08/2021

AGENCY APPROVED DATE: 02/10/2021

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NEED FOR THE RULE(S):

This change is necessary to ensure prudent oversight and monitoring of CCO care coordination obligations for OHP members enrolled in CCOs. The revisions provide clarification of reporting periods and submission to OHA.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits because this temporary rule is necessary to ensure proper oversight of CCO's obligations for care coordination services for some of Oregon's most vulnerable and high risk populations. This reporting will allow OHA to monitor CCO activities to ensure access to needed services for OHP members.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

CCO contract deliverable templates are viewable at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

AMEND: 410-141-3860

RULE TITLE: Integration and Coordination of Care

RULE SUMMARY: The OHP program administrative rules govern the Division's payments for services provided to clients. The Authority needs to temporarily amend 410-141-3860. This change is necessary to ensure prudent oversight and monitoring of CCO care coordination obligations for OHP members enrolled in CCOs. The revisions provide clarification of reporting periods and submission to OHA.

RULE TEXT:

(1) In order to achieve the objectives of providing CCO members integrated person-centered care and services, CCOs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs shall be required to document and report on the requirements in this rule in accordance with section (20) of this rule.

(2) CCOs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.
(3) CCOs shall coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:
(a) With the services the member receives from any other CCO, and for FBDE members, from Medicare providers and, where applicable, MA or DSNP plans;
(b) With the services the member receives in FFS Medicaid; and
(c) With the services the member receives from community and social support providers.
(4) CCOs shall develop evidence-based and, whenever possible, innovative flexible and creative strategies, for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.
(5) To the maximum extent feasible, CCOs shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs by:
(a) Making PCPCHs the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;
(b) Developing and implementing mechanisms that encourage providers to communicate and coordinate care with PCPCHs in a timely manner, using electronic health information technology when the technology is available; and
(c) Engaging other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.
(6) If, in addition to the use of PCPCH, a CCO implements other models of patient-centered primary health care, the CCO shall ensure member access to effective coordinated care services that include wellness and prevention services, active management and support of members with special health care needs, including those members receiving Medicaid long-term services and supports (LTSS), a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. To that end the CCO shall be required to:
(a) Ensure each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type. If the member does not choose a primary care provider or primary care team within 30 calendar days from the date of enrollment, the CCO shall ensure the member has an ongoing source of primary care appropriate to their needs by formally designating a practitioner or entity. CCOs shall document in each member's case file all efforts made in accordance with this subsection (a);
(b) Ensure that each member has an ongoing source of care appropriate to their needs, including regular access to specialty care for members with chronic conditions or disabilities, and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided with information on how to contact their designated person or entity;
(c) Develop services and supports for primary and behavioral health care that meet the access to care requirements set forth in OAR 410-141-3515 and which are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall also ensure that all other services and supports meet the access to care requirements set forth in OAR 410-141-3515; and
(d) Allow eligible members who are American Indian/Alaska Native to select as their primary care provider:
(A) An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or
(B) An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.
(7) MCEs shall establish and enter into hospital and specialty service agreements that include the role of PCPCHs and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for

after-hospital follow up appointments.
(8) CCOs shall meet all of the following requirements relating to transitions of care:
(a) Require hospitals and specialty services to be accountable for achieving successful transitions of care;
(b) Ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings and provided the supportive services needed to ensure successful transition. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, skilled nursing or other long term care settings, and the State Hospital;
(c) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service to a CCO, the CCO shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an CCO participating provider;
(d) Implement systems to assure and monitor transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the processes for members accessing care coordination;
(e) For members who are discharged to post hospital extended care by being admitted to skilled nursing facility (SNF), the CCO shall notify the appropriate Department office and coordinate appropriate discharge planning and ensure services are in place prior to discharge. The CCO shall pay for the full 20-day post-hospital extended care benefit when the full 20 days is required by the discharging provider, if the member was enrolled in the CCO during the hospitalization preceding the nursing facility placement:
(A) CCOs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC) that the post-hospital extended care will be paid for by the CCO;
(B) For members who are discharged to Medicare Skilled Care Unit within a SNF, the CCO shall notify the appropriate Department office when the CCO learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care; and
(C) CCOs shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.
(f) CCOs shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs (as defined under OAR 309-032-0860(30)) between levels or episodes of care. Specific requirements for CCO care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.
(9) CCOs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs as follows:
(a) Establishing procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;
(b) Developing and entering into memoranda of understanding (MOUs) or contracts with the local type B Area Agency on Aging or the local office of the Department's APD that details their system coordination agreements regarding members receiving Medicaid-funded LTCSS; and
(c) Developing and entering into MOUs or contracts with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget. For FBDE members, MCEs shall coordinate Medicare covered behavioral health benefits and Medicaid behavioral health benefits to ensure members receive appropriate and medically necessary care, including preventative screenings and assessments.

(10) CCOs shall cover and reimburse inpatient psychiatric services, except when those services are provided at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010 and OAR 410-141-3500. The state may, however, make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services provided at an IMD as an alternative setting to those covered under the state plan, when all of the following requirements are met in accordance with 42 CFR 438.6(e):
(a) The member receiving services is aged 21-64;
(b) The services are provided for a short-term of no more than 15 days during the period of the monthly capitation payment; and
(c) The provision of services at the IMD meets the requirements for "in lieu of services" as set forth in 42 CFR 438.6(e)(2)(i) through (iii), which requires all of the following:
(A) The IMD is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
(B) The CCO must offer members the option to access the state plan services and shall not require members to use the IMD as an alternative service or setting; and
(C) The approved in lieu of services are authorized and identified in the CCO contracts and offered to members at the CCO's option.
(11) If a member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the CCO shall communicate with the member, the member's representative, and the Medicaid funded long-term care provider or facility, and the DHS or AAA case manager about integrated and coordinated care services.
(12) CCOs shall ensure their participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. The CCOs shall also ensure that they facilitate information exchanges between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). Compliance with the requirements under this section (12) shall be documented and reported to the Authority in the form and manner required by the Authority in accordance with OAR 410-141-3525:
(a) CCOs shall require that providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with their Health Equity Plan Training and Education described in 410-141- 3735;
(b) CCOs shall communicate their integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.
(13) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. CCOs shall coordinate the care of members who enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the Oregon State Hospital and when they are transitioning out of the Oregon State Hospital.
(14) Except as provided in OAR 410-141-3800, CCOs shall coordinate a member's care outside the CCO's service area or, when medically necessary specialty care is not available in Oregon, out-of-state care. CCOs shall coordinate member care even when services or placements are outside the CCO service area. Temporary placements by the Authority, Department, or providers who are responsible for health service placements for services including residential placements, may be located outside the service area; however, the CCO shall coordinate care while in placement and discharge planning for return to the home CCO. For out of service area placements, an exception shall be made for the member to retain home CCO enrollment while the member's placement is a temporary residential placement as defined in OAR 410-141-3500, or elsewhere in accordance with OAR 410-141-3815. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan when the member returns to their home CCO as defined on OAR

410-141-3500.
(15) CCOs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay for the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 CCO Service Authorization.
(16) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing behavioral health crises and to prevent inappropriate use of the emergency department or jails.
(17) CCOs shall perform care coordination in a manner that is trauma-informed, culturally responsive, and which promotes dignity for individuals with disabilities or chronic conditions, as those terms are defined in OAR 410-141-3500.
(18) CCOs shall implement at least one outcome measure tool for care coordination services at the ICC Care Coordination level. CCOs shall collaborate with the Authority to develop statewide standards for care coordination and ICC.
(19) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a Care Coordination report submitted to the Authority under the following timelines:
(a) For the reporting period of April 1, 2021 through September 30, 2021, reports shall be prepared as two quarterly reports, each of which must be submitted to OHA within 45 calendar days from the end of the corresponding calendar quarters;
(b) CCOs will not be required to submit a report for the period of October 1, 2021 through December 31, 2021;
(c) Beginning in Calendar Year 2022, CCOs shall submit semi-annual reports for the reporting periods of January 1 through June 30 and July 1 through December 31, each of which must be submitted to OHA within 45 calendar days from the end of the corresponding reporting period.
(d) The CCO is subject to appropriate corrective action by the Authority if the contents of the report reveal that the CCO's care coordination requirements are not being met. For each reporting period the report must contain:
(A) Identification of care coordination services used with members and the frequency with which each of those practices were used;
(B) Identification of the number of members who qualify for ICC services;
(C) Identification of the number of members receiving ICC services, the type of ICC services provided, and the demographics of such members, consistent with REALD reporting requirements found in OARs 943-070-0000 through 943-070-0070;
(D) An overall review of care coordinators performing services for the CCO, separated by employed and delegated or subcontracted care coordinators;
(E) Identification of any significant events that occurred to members, including, without limitation:
(i) Incarceration;
(ii) Reassessment triggers; and
(iii) Sentinel events. For the purpose of this rule, Sentinel Event is defined as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness;
(F) Data on the type and frequency of reassessment triggers;
(G) Identification of the number of members who received services in coordination with MA or DSNP plans and Medicaid funded LTSS programs and services;
(H) Plans and strategies to improve care coordination with network providers;
(I) Identification of milestones and accomplishments; and
(J) A plan to improve the overall process of care coordination access for its Members. The plan shall also include discussion of gaps in care coordination services and populations that need additional support and plans for improving

the care coordination system within their CCO. The plan is subject to approval by the CCOs' governing boards.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685