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

FILING CAPTION: Care Coordination Rules Being Updated to Clarify Requirements of CCOs to Improve Care Coordination Activities.

EFFECTIVE DATE: 02/01/2024

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RULES:
410-141-3500, 410-141-3860, 410-141-3865, 410-141-3870

AMEND: 410-141-3500

NOTICE FILED DATE: 11/14/2023

RULE SUMMARY: Definitions

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR chapter 410, division 141. The ~~Authority~~Oregon Health Authority (Authority) also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.¶
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final M~~CE~~anaged Care Entity (MCE) claims decision or the Authority issuing a final hearings decision. For a final Managed Care Entity (MCE) claims decision, the date of "Adjudication" is the date on which an MCE has both (a) processed and (b) either paid or denied a Member's claim for services.¶
(3) "Aging and People with Disabilities (APD)" means the division in the Oregon Department of Human Services (~~Department~~ODHS) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.¶
(4) "Area Agency on Aging (AAA)" means the designated entity with which the ~~Department~~ODHS contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.¶
(5) "The Authority" means the Oregon Health Authority (OHA).¶
(6) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; C~~MS~~enters for Medicare and Medicaid Services (CMS) Section 1557 of the Affordable Care Act (ACA) outlines requirements for health plans and providers on alternative formats.¶
(7) "Auxiliary Aids and Services" means services available to members as defined in 45 C~~FR~~ode of Federal

Regulations (CFR) Part 92.¶
(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and ŧThe Oregon Health Authority are in effect.¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.¶
(11) "Capitated Services" means those covered services that an MCEanaged Care Entity (MCE) agrees to provide for a capitation payment under contract with the Authority.¶
(12) "Capitation Payment" means monthly prepayment to an MCEanaged Care Entity (MCE) for capitated services to MCEanaged Care Entity (MCE) members.¶
(13) "Care Plan" means a documented plan that addresses the supportive, therapeutic, cultural, and linguistic health of a member. The member'sCoordination" means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member. Care Coordination requirements are described in OAR 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with CFR 438.208.¶
(14) "Care Plan" means a care plan sthall bet is developed for and in collaboration with the Mmember and the Member's, their family or, representative,s or guardian; and, if applicable,n consultation with the Mmember's caregiver so that it incorporates their preferences and goals to ensure engagement and satisfactionproviders, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs. Care pPlans include, without limitation:¶
(a) Prioritized goal requirements are described in OAR 410-141-3865 and 410-141-3870. ¶
(15) "Care Profile" means the electronic record a CCO develops and maintains for all member's health;¶
(b) Identifying interventions and resources that will benefit and support the member's goals such as peer support, non-traditional services, community services, employs. The Care Profile is the platform that receives feeds from different data sources used to identify, track and manage a member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the member. Care Profile requirements and housing support;¶
(c) Medicare further described in OAR 410-141-3865 and OAR 410-141-3870.¶
(16) "Care Setting Transitions" meanagement; and¶
(d) Monits a transition between different locations, settings or levels of care. ¶
(17) "Coordin and re-evaluation.¶
(14) "ated Care Organization Payment or CCO Payment" means the monthly payment to a CCOoordinated Care Organization (CCO) for services the CCO provides to members in accordance with the global budget.¶
(158) "Certificate of Authority" means the certificate issued by DCBSepartment of Consumer and Business Services (DCBS) to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.¶
(169) "Client" means an individual found eligible to receive Oregon Health Plan (OHP) health services, whether or not the individual is enrolled as an MCECCO member.¶
(1720) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.572 and in accordance with criteria specified in ORS 414.575. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:¶
(a) In a Service Area where only one (1) federally recognized tribe exists, the CCO shall seek one (1) tribal representative to serve on the CAC;¶
(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one (1) tribal representative from each tribe to serve on the CAC; and¶
(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.¶
(218) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.¶
(1922) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:¶
(a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to;¶
(A) Alcohol;¶
(B) Illicit Drugs; and¶

(C) Gambling.¶
(b) Physical Health conditions, including but not limited to:¶
(A) Cancer;¶
(B) Diabetes; ¶
(C) Bariatric Ie.¶
(c) Developmental Disabilities.¶
(23) "Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.¶
(2~~0~~4) "Contract" means an agreement between the State of Oregon acting by and through ~~t~~The Authority and a~~n~~ Managed Care Entity (MCE) to provide health services to eligible members.¶
(2~~1~~5) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.¶
(2~~2~~6) "Coordinated Care Services" mean a~~n~~ M~~CE's~~anaged Care Entity's (MCE) fully integrated physical ~~health~~, behavioral ~~health services, and dental~~, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) services.¶
(2~~3~~7) "Corrective Action" or "Corrective Action Plan (CAP)" means an Authority-initiated request for a~~n~~ Managed Care Entity (MCE) or a~~n~~ Managed Care Entity (MCE)-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.¶
(24~~8~~) "Culturally and Linguistically Responsive and Appropriate Services" means the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and Linguistically appropriate services are further defined in 42 CFR 59.2.¶
(29) "Delivery System Network (DSN)" means the entirety of those Participating Providers who~~.~~:¶
(a) ~~c~~Contracts with~~,~~; or ¶
(b) ~~a~~Are employed by, a~~n MCE~~ CCO for purposes of providing services to the Members of such ~~MCE~~CCO. "Provider Network" has the same meaning.¶
(~~25~~30) "Dental Care Organization (DCO)" has the meaning as provided for in ORS 414.025 (24).¶
(~~26~~31) "~~The~~ Dental Health" means conditions of the mouth, teeth, and gums.¶
(32) "Department" means the Oregon Department of Human Services (ODHS).¶
(~~27~~33) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.¶
(~~28~~34) "Disenrollment" means the act of removing a member from enrollment with an MCE.¶
(~~29~~35) "Diversity of the ~~W~~workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.¶
(3~~0~~6) "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818 and under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided: ¶
(a) Were covered services, non-covered services, or other Health-Related Social Needs services; or¶
(b) Were not paid; or¶
(c) Paid for on a Fee- For-Service or capitated basis; or¶
(d) Were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and ¶
(e) Were performed pursuant to Subcontractor agreement, special arrangement with a facility or program, or other arrangement.¶
(3~~1~~7) "Enrollment" means the assignment of a member to a~~n~~ Managed Care Entity (MCE) for management and coordination of health services.¶
(3~~2~~8) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health ~~p~~Plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:¶
(a) Annual exams;¶
(b) Contraceptive education and counseling to address reproductive health issues;¶
(c) Prescription contraceptives (such as birth control pills, patches or rings);¶

(d) IUDs and implantable contraceptives and the procedures requires to insert ~~an~~ed remove them;¶
(e) Injectable hormonal contraceptives (such as Depo-Provera);¶
(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);¶
(g) Laboratory tests including appropriate infectious disease and cancer screening;¶
(h) Radiology services;¶
(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.¶
(3~~3~~9) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits.¶
(3~~4~~0) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.¶
(3~~5~~41) "Grievance System" means the overall system that includes:¶
(a) Grievances to a~~n~~ Managed Care Entity (MCE) on matters other than adverse benefit determinations;¶
(b) Appeals to a~~n~~ Managed Care Entity (MCE) on adverse benefit ~~de~~terminations; and¶
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.¶
(3~~6~~42) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.¶
(4~~3~~7) "Health-Related Services (HRS)" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.¶
(3~~8~~44) "Health ~~System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP.¶~~
~~(39) "Holistic Care" mean~~Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a member, their representative or guardian about key areas of their health, including their physical, developmental, behavioral, dental and social needs (inc~~orporating the care of the entire memb~~luding Health Related Social Needs and Social Det~~er~~er-min~~-all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, such as the practices of naturopathy or chiropractic and often involving nutritional measures~~ants of Health). The HRA is intended to inform the coordination of services and supports that meet the members individualized needs as described in OAR 410-141-3860, 410-141-3865 and 410-141-3870.¶
(45) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of Oregon Health Plan (OHP).¶
(4~~0~~6) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through O~~HP~~regon Health Plan (OHP) fee-for-service, based on permanent residency.¶
(4~~1~~7) "Indian" and/or "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).¶
(4~~2~~8) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).¶
(4~~3~~9) "In Lieu of Service" (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).¶
(4~~4~~50) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.¶
(45~~1~~) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.¶
~~(46) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.¶~~

(4752) "Legal Holiday" means the days described in ORS 187.010 and 187.020.¶
(4853) "Licensed Health Entity" means an Managed Care Entity (MCE) that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.¶
(549) "Managed Care Entity (MCE)" is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
¶
(505) "Managed Care Organization (MCO)" is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.¶
(516) "Material Change to Delivery System" means:¶
(a) Any change to the CCO's Delivery System Network (DSN) that may result in more than five (5) percent of its members changing the physical location(s) of where services are received; or¶
(b) Any change to CCO's DSN that wouldmay likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type; or¶
(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or¶
(d) Any combination of the above changes.¶
(527) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:¶
(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;¶
(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.¶
(538) "Member" means an OHPregon Health Plan (OHP) client enrolled with an MCE CCO.¶
(549) "Member Representative" means an individual who can make OHPregon Health Plan (OHP)-related decisions for a member who is not able to make such decisions themselves.¶
(5560) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.¶
(561) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.¶
(5762) "Ombudsperson Services" means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.¶
(58) "Oral Health" means conditions of the mouth, teeth, and gums.¶
(5963) "Oregon Health Plan (OHP)" means Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both.¶
(604) "Oregon Integrated and Coordinated Health Care Delivery System" means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.570.¶
(615) "Participating Provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(626) "Patient-Centered Primary Care Home (PCPCH)" means a recognized clinic that takes a patient and family-centered approach to all aspects of care. PCPCHs work with the member and their health care team to improve and coordinate care and help to eliminate repetitive procedures. As defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040 and means the definition as set forth in OAR 409-055-0010. ¶
(67) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.¶

(6~~3~~8) "P~~ost-~~lan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶
(a) CCOA: Physical, dental, and behavioral health services are paid by the client's CCO;¶
(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Dental services are paid the fee-for-service program;¶
(c) CCOE: Behavioral health services are paid by the client's CCO. Physical health and dental services are paid by the fee-for-service program;¶
(d) CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120. Any reference to CCOF means the benefit package covers dental services only; and¶
(e) CCOG: Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.¶
(69) "Post Hospital Extended Care Services" (PHECS). Consistent with 42 USC 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than ~~3~~three (3) consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility:¶
(a) Within thirty (30) days after discharge from such hospital; or¶
(b) Within such time as it ~~would~~may be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care ~~would~~may not be medically appropriate within thirty (30) days after discharge from a hospital; and¶
(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within thirty (30) days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.¶
(~~64~~70) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.¶
(~~65~~71) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:¶
(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;¶
(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-0~~27~~55-001~~05~~ and OAR 410-120-0000.¶
(~~66~~72) "Provider" means an individual, facility, institution, corporate entity, or other organization that:¶
(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or¶
(b) Bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a Provider, (and also termed a "Billing Provider"); and¶
(c) Supplies health services or items (also termed a "Rendering Provider").¶
(~~67~~3) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.¶
(~~68~~74) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.¶
(~~69~~75) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:¶
(a) An infant, child or youth, between the ages of birth to 21 years of age; and¶
(b) Must meet criteria for diagnosis, functional impairment and duration:¶
(A) Diagnosis: The infant, child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):¶
(i) For children ~~3~~three (3) years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and

Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);¶
(ii) For children ~~4~~four (4) years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).¶
(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;¶
(C) Duration: The identified disorder and functional impairment must have been present for at least ~~1~~one (1) year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than ~~1~~one (1) year.¶
(7~~0~~6) Social Determinants of Health and Equity (SDOH-E) each has the meaning provided for in OAR 410-141-3735.¶
(77) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or ~~S~~substance ~~U~~use ~~D~~disorders and either:¶
(a) Have functional disabilities;¶
(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or¶
(c) Are a ~~Member of the Prioritized Populations as defined in OAR 410-141-3870~~Prioritized Population member. This includes members who:¶
(A) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;¶
(B) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);¶
(C) Are children ages 0-5:¶
(i) Showing early signs of social/emotional or behavioral problems; or¶
(ii) Have a Serious Emotional Disorder (SED) diagnosis.¶
(D) Are in medication assisted treatment for SUD;¶
(E) Are women who have been diagnosed with a high-risk pregnancy;¶
(F) Are children with neonatal abstinence syndrome;¶
(G) Children in Child Welfare;¶
(H) Are IV drug users;¶
(I) People with SUD in need of withdrawal management;¶
(J) Have HIV/AIDS or have tuberculosis;¶
(K) Are veterans and their families;¶
(L) Are at risk of first episode psychosis;¶
(M) Individuals within the Intellectual and developmental disability (IDD) populations.¶
(7~~1~~8) "Subcontract" means either:¶
(a) A contract between a~~n MCE~~ CCO and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the ~~MCE~~CCO under its contract with the State; or¶
(b) Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.¶
(7~~2~~9) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.¶
(~~73~~80) "Transition of Care" applies to Medicaid members who are enrolled in a CCO ("the receiving CCO") immediately after disenrollment from a "predecessor plan" which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). Transition of Care does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan. Meets the standards pursuant to OAR 410-141-3850."¶
(81) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-

traumatization of the individuals being served within their respective entities.¶
(~~74~~82) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.¶
(~~75~~83) "Trauma-informed services" means those services provided using a Trauma Informed Approach.¶
(~~76~~84) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that ~~wi~~shall be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.¶
(~~77~~85) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.¶
(~~78~~6) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.¶
~~(79) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶~~
~~(a) CCOA: Physical health, dental, and behavioral health services are paid by the client's CCO;¶~~
~~(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Dental services are paid by the fee-for-service program;¶~~
~~(c) CCOE: Behavioral health services are paid by the client's CCO. Physical health and dental services are paid by the fee-for-service program; ¶~~
~~(d) CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120;¶~~
~~(A) Any reference to CCOF means the benefit package covers that dental services only; and¶~~
~~(B) CCOG: Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.~~
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3860

NOTICE FILED DATE: 11/14/2023

RULE SUMMARY: Care Coordination: Administration, Systems and Infrastructure.

CHANGES TO RULE:

410-141-3860
~~Integration and Coordination of Ca~~Care Coordination: Administration, Systems and Infrastructure
(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 the Authority within 60 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 the Authority within 60 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~~Coordinated Care Organizations (CCOs) must coordinate services for members in accordance with 42 CFR §438.208, OAR 410-141-3865, OAR 410-141-3870 and this rule. This coordination must encompass all services accessed to address the member's physical, developmental, behavioral, dental and social needs (including Health-Related Social Needs (HRSN) and Social Determinants of Health and Equity (SDOH-E). To meet these requirements, CCO's must:¶
(a) Identify the needs of their members on an initial and ongoing basis as described in OAR 410-141-3865;¶
(b) Ensure coordinated services are provided to their members as described in OAR 410-141-3870; and¶
(c) Ensure their members are informed about the availability of Care Coordination and how to access or request it initially and ongoing.¶
(2) CCOs must ensure the overall coordination of all services and supports furnished to the member, regardless of who provides the service. CCOs are responsible for coordinating with Medicaid Fee-For-Service (FFS), Medicare or Medicare Advantage Plans, Community Mental Health Programs (CMHP), Oregon Department of Human Services (ODHS), including Aging and People with Disabilities (APD), Child Welfare (CW), and Developmental Disability Services (DDS), Oregon Department of Education (ODE), Oregon Youth Authority (OYA), Local Public and Mental Health Authorities and any other community and social support organizations.¶
(3) Primary responsibility for Care Coordination is determined based on the member's CCO Plan Type.¶
(a) If a member is enrolled in Plan Type CCOA or CCOB the CCO is primarily responsible for Care Coordination and must ensure the coordination of all services and supports furnished to the member by any other entity referenced in (2) of this rule.¶
(b) If a member is enrolled in Plan Type CCOE, CCOF or CCOG, the Oregon Health Authority's Medicaid Fee-For-Service (FFS) program is primarily responsible for Care Coordination. The CCO must proactively collaborate with FFS Care Coordination and other providers serving the member to maintain awareness of identified needs and existing Care Plans and to ensure the services covered by the CCO are coordinated.¶
(4) The entities in Section (2) of this rule may all have some level of responsibility for a member's care. Therefore, the fundamental role the CCO must fill is to facilitate, collaborate and oversee any relevant coordinating entities and lead when necessary as required in Section (3)(a) of this rule.¶

(5) When a member is engaged in multiple programs (e.g., Long Term Services and Supports, Intellectual and Developmental Disabilities, Child Welfare, Youth Wraparound, Intensive In-home Behavioral Health Treatment) where there are care teams or coordinators involved the CCO's responsibility is to collaborate with those entities who are coordinating services the member is receiving in order to reduce duplication and identify Care Coordination gaps.¶
(a) If the CCO is collaborating with another program the CCO is required to be aware of and document the coordinating entities activities to understand and identify additional unmet needs the member may have that require Care Coordination be provided by the CCO.¶
(b) The CCO is responsible for leading and facilitating Care Coordination for all needs identified that are not addressed or coordinated by another program or entity.¶
(6) Care Coordination is intended to continuously:¶
(a) Improve member health outcomes;¶
(b) Ensure a member's ability to live well with and manage any chronic conditions or disabilities;¶
(c) Improve member satisfaction;¶
(d) Reduce health inequities; and¶
(e) Reduce barriers to accessing health care.¶
(7) In all aspects of its systems and practice, Care Coordination must be:¶
(a) Person-centered and for minors, person-and family-centered;¶
(b) Trauma-informed and responsive;¶
(c) Culturally, linguistically and developmentally responsive and appropriate;¶
(d) Accessible to all members, including those with disabilities and persons who experience Limited English Proficiency and equitable access to services, consistent with 42 CFR 435.905 and ORS 413.550;¶
(e) Delivered with a whole-person approach that encourages member self-determination and autonomy;¶
(f) Designed to account for the unique contextual needs of various member populations in relation to their families and communities, such as children, youth, young adults, and older adults, so that every member's needs are identified and addressed in a way that is appropriate for their situation; and¶
(g) Focused on prevention, safety, early identification, intervention, and ongoing management.¶
(8) CCOs must develop and continuously improve the infrastructure (e.g., systems, technology solutions, processes, relationships, and agreements) needed to support, enable, and uphold their responsibility to coordinate services for their members. This infrastructure is not limited to, but must address:¶
(a) Management and implementation, including at minimum:¶
(A) Implementing and utilizing a care management platform to track and monitor care coordination activities (e.g., document, track, and report care plan goals and outcomes, members' care team, communication to/from care team, community resources, completed assessments and identified needs, change in health-related circumstances), communication with individual members, and timeliness of activities. To the maximum extent feasible, CCOs may establish system interfaces with community partners and providers.¶
(B) Implementing and utilizing member data to develop a risk stratification model and mechanism to stratify members by the following risk categories, at a minimum: no- or low-risk, moderate-risk, high-risk. The Oregon Health Authority (Authority) must approve CCOs' risk stratification mechanisms and algorithms before implementation.¶
(i) Data sources used to identify risk level and care gaps must include but are not limited to the following sources: claims and utilization data, Health Risk Assessments, functional need assessments, social needs and risks, referrals, event notifications, and other available resources to inform physical, developmental, behavioral, and dental health needs;¶
(ii) Risk scores shall be utilized to inform the level of intensity and intervention required by the member and incorporated into the members care profile;¶
(iii) Continuous and ongoing data mining and identification of additional care gaps shall inform updates to the member's risk level and intervention needed.¶
(C) Regularly monitoring population level trends to determine and identify cohorts of the population requiring Care Coordination due to an emergent need;¶
(D) Developing monitoring mechanisms to regularly track timeliness, adequacy, and effectiveness of Care Coordination efforts and outreach by the CCO and providers, or subcontracted entity if Care Coordination is delegated;¶
(E) Tracking data required for reporting and ongoing improvement efforts;¶
(F) Maintaining policies, procedures, workflows, and desk processes to support CCO staff or subcontractors in managing Care Coordination activities;¶
(G) CCOs shall follow the grievance and appeal system requirements outlined in OAR 410-141-3875, OAR 410-141-3880, OAR 410-141-3885, OAR 410-141-3890, OAR 410-141-3895, OAR 410-141-3900, OAR 410-141-3905, OAR 410-141-3910, and OAR 410-141-3915 for grievances and appeals pertaining to Care Coordination.¶

(H) Abide by, or enter into as needed, any agreements or Memoranda of Understanding (MOUs) governing coordination with other entities described in (2) of this rule, including at minimum but not limited to, Aging and People with Disabilities (APD) or Type B Area Agency on Aging (AAA) for Long Term Services and Supports.¶
(I) Maintaining training and qualification requirements for CCO staff and subcontracted entities;¶
(J) Using creative and innovative strategies to develop and build member engagement;¶
(K) Maintaining a contact point for the escalation of emergent or unmet Care Coordination needs for use at any time by members, their representative or guardian, providers or other entities.¶
(b) Record keeping, mutual exchange of information, and privacy, including at minimum:¶
(A) Documentation and record keeping of member information in accordance with OAR 410-141-3520;¶
(B) The systems and processes (e.g., data sharing agreements, electronic health information exchange) needed for mutual exchange of information between the CCO, providers and community partners;¶
(C) Developing and entering into agreements or Memoranda of Understanding (MOUs) with providers and/or member serving systems or organizations not contracted with the CCO to ensure mutual exchange of information of a member's physical, behavioral, dental, and social needs information across all entities, providers, and systems involved in Care Coordination;¶
(D) Requiring Primary Care and other CCO contracted providers to communicate and coordinate care with each other and with the CCO in a timely manner, using electronic health information technology, as available, or through other mechanisms (e.g. paper-based systems); and¶
(E) The member having access to, and the ability to share, protected health information with others involved in their care as set forth in 45 CFR § 164.524.¶
(c) Access to Care, including at minimum:¶
(A) Establishing, maintaining and monitoring a network of participating providers to ensure the provision of an ongoing source of care appropriate to the needs of its members in accordance with OAR 410-141-3515;¶
(B) Contracting with Patient-Centered Primary Care Homes (PCPCH) to provide members a consistent and stable relationship with a care team, and supporting and collaborating with them in the overall coordination of the member's care;¶
(C) Developing and entering into agreements, memoranda of understandings (MOUs) with providers and other entities not contracted with the CCO, to ensure a member's access to coordinated physical, behavioral, dental, and social needs services across multiple providers;¶
(D) Using Value Based Payments to encourage specialty and Primary Care Providers to coordinate care;¶
(E) Assignment to a Primary Care Provider if the member has not selected a Primary Care Provider by the 90th day after enrollment in the CCO. The CCO shall provide notice of the assignment to the member and to the Primary Care Provider.¶
(i) A member may select a different Primary Care Provider at any time and/or request assistance with selecting an appropriate provider.¶
(ii) Eligible members who are American Indian/Alaska Native may select as their primary care provider:¶
(I) An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or¶
(II) An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.¶
(F) Maintenance of a policy and procedure that informs members, their Non-Emergency Medical Transportation (NEMT) providers and call centers of the availability of NEMT services for Care Coordination activities.¶
(d) Subcontractor and provider oversight, including at minimum:¶
(A) Ongoing and regular monitoring and reporting to ensure compliance, and appropriate support, for any delegated Care Coordination activities, in accordance with 42 CFR §438.208, OAR 410-141-3865, OAR 410-141-3870, and this rule;¶
(B) CCOs must take corrective action to address any deficiencies identified through monitoring and reporting.¶
(9) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a Care Coordination report submitted to the Authority under the timelines specified by the Authority in CCO Contract.¶
(a) The Authority shall provide tools and additional guidance specific to reporting requirements on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶
(b) The Authority may determine additional deliverables are necessary to appropriately oversee CCOs' implementation of Care Coordination requirements.¶
(10) If CCOs are not in compliance with these rules OHA may impose sanctions as described in CCO contract and OAR 410-141-3530.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3865

NOTICE FILED DATE: 11/14/2023

RULE SUMMARY: Care Coordination: Identification of Member Needs.

CHANGES TO RULE:

410-141-3865
Care Coordination ~~Requirements~~: Identification of Member Needs
(1) ~~CCOs shall ensure continuous care management for all members.¶~~
~~(2) For the purpose of~~In order to coordinate a member's services as described in this rule, OAR~~s~~ 410-141-3860 ~~-~~ and OAR 410-141-3870, ~~the following meanings apply:¶~~
~~(a) "Health Risk Screening" means:¶~~
~~(A) A systematic collaborative approach by the CCO and provider to collecting information from a Member about key areas of their health for the purpose of:¶~~
~~(i) Assessing the Member's health;¶~~
~~(ii) Evaluating the Member's level of health risk; and¶~~
~~(iii) Providing the Member with individualized feedback about the results of the screening and evaluation with the goal of motivating behavioral changes to reduce health risks, maintain health, and prevent disease~~Coordinated Care Organizations (CCOs) must have mechanisms in place to identify the member's physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity), goals, and preferences of members on an initial and ongoing basis.¶
(~~B~~2) ~~Results of the Health Risk Screening shall be documented in the member's care plan;¶~~
~~(C) Health Risk Screenings are usually administered through a survey or questionnaire. Suggested areas of information to collect include questions, depending on the Member's age, regarding:¶~~
~~(i) Demographics, such as age, gender, relationship status;¶~~
~~(ii) Lifestyle behaviors, such as exercise, eating habits, alcohol and tobacco use, activities of daily living;¶~~
~~(iii) Living Conditions such as access to food, housing and related living conditions;¶~~
~~(iv) Behavioral/emotional health, such as stress, mood, life events, abuse;¶~~
~~(v) Physical health, such as weight, height, blood pressure; ¶~~
~~(vi) Personal and family health history; and¶~~
~~(vii) Dental health. ¶~~
~~(b) "Intensive Care Coordination (ICC) Assessment" means the utilization of standardized tools, instruments, or processes for the purpose of identifying, and creating individual, personalized treatment~~CCOs must conduct a Health Risk Assessment (HRA) within ninety (90) days of enrollment, or sooner if a member's health condition requires, and must:¶
(a) Conduct the HRA according to the evaluation checklist provided by the Oregon Health Authority (OHA) and available on the Quality Assurance Material Submission and ~~service plans to address the specific physical, behavioral, oral, and social needs of Priority Population Members, as well as o~~Review page;¶
(b) Make the HRA available to members, their ~~Members who have been identified, as a result of their Health Risk Screen~~representative or guardian orally, in writings, ~~as potentially in need of ICC Services, or having experienced a triggering event as set forth in~~or online;¶
(c) Document all attempts made to reach the member in accordance with OAR 410-141-3~~870(9).~~520;¶
(3d) ~~CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member~~Review and document a member's HRA in their Care Profile or Care Plan, if applicable, in accordance with OAR 410-141-3870~~. This screening is distinct from the assessment of special health care needs:¶~~
~~(a) CCOs shall use a screening process to evaluate all members for critical risk factors that trigger the need for intensive care coordination for members with special health care needs;;¶~~
(e) Share with other entities and providers serving the member the results of any HRA to prevent duplication of those activities; and¶
(~~b~~f) ~~Members shall be screened upon initial enrollment with their CCO. This screening shall be completed as follows:¶~~
~~(A) Within 90 days of the effective date of initial enrollment;¶~~
~~(B) Within 30 days of the effective date of initial enrollment when the member is:¶~~
~~(i) Referred; ¶~~
~~(ii) Receiving Medicaid-funded long-term care, services and supports (LTSS); or¶~~
~~(iii) Is a member of a priority population as such term is defined in OAR 410-141-3870.¶~~
~~(C) Sooner than required under (3)(b)(A) or (B) of this rule if required by the member's health condition.¶~~
~~(c) CCOs shall rescreen members annually or sooner if there is a change in health status indicating need for an~~

~~updated assessment. Members shall be rescreened in accordance with this section (3)(c) of this rule even if they have previously declined care coordination or ICC services;¶~~
~~(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;¶~~
~~(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.¶~~
~~(4) CCOs shall document all screenings and assessments in the member's case file:~~When the member, their representative or guardian has not returned or responded to the HRA, the CCO must:¶
(A) Follow up with the member if additional information, or support with completion, is needed. This shall include making a minimum of three (3) attempts to contact the member to facilitate completion and identification of the member's needs. The attempts to reach a member shall utilize at least two (2) mixed modalities (e.g., telephonic, text, email, letter), on different days, and at different times;¶
(a~~B~~) ~~If a CCO requires additional information from the member to complete a screening or assessment, the CCO shall document all attempts to reach the member by telephone and mail;¶~~
~~(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;¶~~
~~(c) CCOs shall share the results of member assessments and screenings consistent with ORS 414.607 and all other applicable state and federal privacy laws with the following:¶~~
~~(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;¶~~
~~(B) The state or other MCEs serving the member;¶~~
~~(C) Members receiving LTSS and, if approved by the member, their case manager and their LTSS provider, if approved by the member; and¶~~
~~(D) With Medicare Advantage or DSNP plans serving dual eligible members~~Use other available data sources, including but not limited to those identified in OAR 410-141-3860(8) and (3) of this rule, to identify sufficient information to assign a risk level to the member; and¶
(C) Ensure services are coordinated for members regardless of their participation in or completion of the HRA.¶
(~~5~~3) CCOs shall ~~have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and for identifying those members requiring referral to the Department for LTSS.¶~~
~~(6) CCOs shall require their care coordinators to develop, and CCOs shall require their provider netw~~consider relevant information from a variety of sources to inf~~o~~r~~k~~m t~~o use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ICC needs, including those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving LTSS.¶~~
~~(7) A member's care plan must at a minimum:¶~~
~~(a) Incorporate information from treatment plans from providers~~he development or update of a member's Care Profile, and/or Care Plan, if applicable, as described in OAR 410-141-3870 (4) and (5). This includes, but is not limited to:¶
(a) Progress notes from any entity involved in the member~~'~~s care~~, and, if appropriate and with consent of the member, information provided by community partners;¶~~
~~(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the m~~ coordination team;¶
(b) Any relevant assessments; ¶
(c) New medical diagnoses, courses of treatment, and em~~ber~~;¶
~~(c) Make provision for authorization of services in accordance with OAR 410-141-3835;¶~~
~~(d) For members enrolled in ICC or a condition-specific program, Intensive Care Coordination Plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner i~~gent needs;¶
(d) Social needs (including Social Determinants of ~~h~~Health ~~care needs change.¶~~
~~(8) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:¶~~
~~(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered~~and Health Related Social Needs)¶
(e) Utilization of services as a result of claims review;¶
(~~b~~f) ~~To ensure engagement and satisfaction with care plans, care coordinators shall:¶~~
~~(A) Actively engage members in the creation of care plans;¶~~
~~(B) Ensure members understand their care plans; and¶~~
~~(C) Ensure members understand~~ Information received from the member, their representative or guardian or o~~th~~e~~ir~~ ~~role and responsibilities outlined in their care plan~~involved providers or community support~~s~~.¶
(~~c~~g) C~~are coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that~~

they understand their role as outlined in the care plan and thathange in health-related circumstances which is defined as, but not limited to, any of they feel equipped to fulfill their responsibilitiollowing occurrences;:¶
(dA) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document theHospital ER visits, hospital admissions or discharges;¶
(B) Mobile Crisis reaspons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and e;¶
(C) Pregnancy diagnosis;¶
(D) Chronic disease diagnosis;¶
(E) Behavioral healthe decision to continue the exclusion shall be documented as detailed in (8)(a)-(d) of this ruleiagnosis;¶
(F) Intellectual/Developmental Disability (I/DD) diagnosis;¶
(eG) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providingEvent that poses a significant risk to the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of thethat is likely to occur or reoccur without intervention;¶
(H) Recent, or at risk for potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above., homelessness or non-placement;¶
(9I) A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.¶
Two or more billable primary ICD-10 Z code diagnoses within one (10) Care coordinators shall perform their care coordination tasks in accordance with the following principles:month;¶
(aJ) Use trauma informed, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-beingTwo or more caregiver placements within past six (6) months;¶
(bK) Work with members to set agreed-upon goals with continued CCO network support for self-management goals;¶
(c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;¶
(d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;¶
(e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needDischarge from a correctional facility, juvenile detention facility, other residential or long-term care settings back to the community or another care setting;¶
(L) Exit from Condition Specific Program or Facility as identifined by the individualin OAR 410-141-3500;¶
(fM) Promote medication manageEnrollment or disenrollment, intensive community-based services and supports and, for ICC members, peer-delivered s other service programs such as Long-Term Services and sSupports; and¶
(g) Have contact with, if the member is participating in a condition-specific program, the active condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.¶
(11) Care coordinators shall promote continuity of care and recovery management through:¶
(a) Episodes of care, regardless of the member's location;¶
(b) Monitoring of conditions and ongoing recovery and stabilization, Intellectual/Developmental Disability services or Children's Intensive In-home services;¶
(N) Orders for Home Health or Hospice services;¶
(cO) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; andNewly identified or change to an identified Health Related Social Need (HRSN);¶
(dP) Engaging members, and their family and caregivers as appropriate.¶
(e) For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.¶
(12) CCOs shall facilitateAn identified gap in network adequacy that leaves the member without a needed service or care;¶

(Q) Life span developmental transitions such as a transition ~~planning for members. In addition to the requirements of OAR 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below:¶~~
~~(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities;¶~~
~~(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:¶~~
~~(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;¶~~
~~(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and¶~~
~~(C) Engage with the member, in person within two days post discharge. For the duration of the Public Health Emergency (PHE), face-to-face contact may occur by synchronous telehealth as defined in OAR 410-141-3566.¶~~
~~(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on an in-person basis whenever possible or face-to-face by synchronous telehealth as defined in OAR 410-141-3566 for the duration of the Public Health Emergency (PHE), as follows:¶~~
~~(A) Within one business day of admission;¶~~
~~(B) Two times per week while the member is in acute care; and¶~~
~~(C) No less than two times per week within the week of discharge.¶~~
~~(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;¶~~
~~(e) In the event a member has a lapse in Medicaid coverage while admitted to a hospital, residential, inpatient, long-term care, or other similarly licensed in-patient facility, CCOs shall also, in addition to providing the services set forth in subsections (a)-(d) of this section (12) of this rule, oversee management of the member's care, work to establish services that may be needed but currently are not available in their service areas, and if eligible, assist in the reinstatement of Medicaid coverage. The CCO's obligation to provide such services shall continue for the period of 60 days from the date the member lost Medicaid coverage or until the member's discharge, whichever occurs sooner.¶~~
~~(13) CCOs shall ensure care coordinators are providing the required and appropriate behavioral, oral, and physical health care services and supports to members. The individual(s) tasked with responsibility for supervising care coordinators, whether employed by a CCO or employed by a Subcontractor providing care coordination services, shall be:¶~~
~~(a) A licensed master's-level mental health professional; or¶~~
~~(b) A licensed nurse by the State of Oregon, holding a Bachelor's degree or higher in nursing.¶~~
~~(14) CCOs shall not subcontract or otherwise delegate the responsibility for ensuring any subcontracted care coordination services and activities meet the requirements set forth in this rule, OARs 410-141-3860, 410-141-3870, and any other applicable care coordination requirements~~from pediatric to adult health care;¶
(R) Entry into, or change of placement while in, foster care.¶
(4) CCOs must implement mechanisms, including but not limited to the HRA and any additional relevant assessments described above, to identify the risk category and needs for:¶
(a) Members with Special Health Care Needs (SHCN) as defined in OAR 410-141-3500; and¶
(b) Members requiring Medicaid Funded Long Term Services and Supports (LTSS) as defined in OAR 410-141-3500.¶
(5) If at any time the member is identified as potentially eligible for, or requiring LTSS, or having a Special Health Care Need, the CCO must also ensure those members are comprehensively assessed, per 42 CFR 438.208(c)(2), as soon as their health condition requires, to identify those members who have an ongoing special condition that requires either a course of treatment or regular care monitoring. ¶
(6) CCOs must ensure appropriate and prompt referral of CCO-identified LTSS members to Oregon Department of Human Services (ODHS) Aging and People with Disability (APD) programs, the Office of Developmental Disabilities Services (ODDS), Local Mental Health Authorities (LMHA) or other service programs where appropriate.
Statutory/Other Authority: 414.615, 414.625, 414.635, 414.651, ORS 413.042
Statutes/Other Implemented: ORS 414.610-414.685

AMEND: 410-141-3870

NOTICE FILED DATE: 11/14/2023

RULE SUMMARY: Care Coordination: Service Coordination

CHANGES TO RULE:

410-141-3870
~~Intensive Car~~Care Coordination: Service Coordination
(1) C~~COs are responsible for Intensive Care Coordination (ICC) services. The requirements described in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 and 410-141-3865.~~¶
~~(2) "Prioritized Populations" means individuals who:~~¶
~~(a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;~~¶
~~(b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);~~¶
~~(c) Are children ages 0-5:~~¶
~~(A) Showing early signs of social/emotional or behavioral problems; or~~¶
~~(B) Have a Serious Emotional Disorder (SED) diagnosis.~~¶
~~(d) Are in medication assisted treatment for SUD;~~¶
~~(e) Are women who have been diagnosed with a high-risk pregnancy;~~¶
~~(f) Are children with neonatal abstinence syndrome;~~¶
~~(g) Children in Child Welfare;~~¶
~~(h) Are IV drug users;~~¶
~~(i) People with SUD in need of withdrawal management;~~¶
~~(j) Have HIV/AIDS or have tuberculosis;~~¶
~~(k) Are veterans and their families;~~¶
~~(L) Are at risk of first episode psychosis;~~¶
~~(m) Individuals within the Intellectual and developmental disability (IDD) populations.~~¶
~~(3) "Intensive Care Coordinator" (ICC Care Coordinator) means a person coordinating ICC services as defined in this rule.~~¶
~~(4) "Intensive Care Coordination Plan" (ICC Plan) means a collaborative, comprehensive, integrated and interdisciplinary-focused written document that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC Services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.~~¶
~~(5) All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children who are members of a prioritized population shall be provided behavioral health services according to presenting needs.~~¶
~~(6) CCOs shall also conduct an ICC assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below in section (6) of this rule. All referrals for ICC assessments shall be responded to by the CCO within one business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening. ICC assessments shall be conducted when:~~¶
~~(a) A health risk screening conducted under, and in accordance with, OAR 410-141-3865 indicates a member has special health care needs or other needs or conditions that may indicate a need for ICC services;~~¶
~~(b) A member refers themselves;~~¶
~~(c) A member's representative or provider, including a home and community-based services provider, refers the member; or~~¶
~~(d) Upon referral of any medical personnel serving as a member's LTCSS case manager.~~¶
~~(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC needs. CCOs shall have established process for responding to all requests for ICC assessments or services, which shall include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one business day.~~¶
~~(8) ICC assessments shall identify the physical, behavioral, oral and social needs of a member.~~¶
~~(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (b)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility revise care plans, and ensure care coordination~~

efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:¶
(a) For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865 and this rule. Contact shall be made with the member by the ICC care coordinator within three calendar days of receipt of notice of a reassessment triggering event;¶
(b) Reassessment triggering events include all of the following events:¶
(A) New hospital visit (ER or admission);¶
(B) New high-risk pregnancy diagnosis;¶
(C) New chronic disease diagnosis (includes behavioral health);¶
(D) New behavioral health diagnosis;¶
(E) Opioid drug use;¶
(F) IV drug use;¶
(G) Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);¶
(H) New I/DD diagnosis;¶
(I) Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;¶
(J) Recent homelessness;¶
(K) Two or more billable primary Z code diagnoses within one month;¶
(L) Two or more caregiver placements within past six months;¶
(M) An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;¶
(N) Discovery of new or ongoing behavioral health needs;¶
(O) Discharge from a residential setting or long-term care back to the community;¶
(P) Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;¶
(Q) Two or more readmissions to an acute care psychiatric hospital in a 6-month period;¶
(R) Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period; and¶
(S) Exit from condition-specific program.¶
(c) Members shall be reassessed for ICC services and care plans or, if applicable, ICC plans shall be revised annually;¶
(d) Reassessment for ICC services and care plans, or if applicable, ICC plans, revised if necessary, shall be performed upon member request.¶
(10) Members eligible for ICC shall be assigned an ICC care coordinator:¶
(a) ICC Care coordinator assignments must be made within three business days of determining a member is eligible for ICC services;¶
(b) If a member is in a condition-specific program at the time they are determined eligible for ICC services, or enters a condition-specific program while receiving ICC services, then the CCO will appoint the care coordinator of the condition-specific program as the ICC care coordinator for the member while the member is in the condition-specific program. After a member transitions from a condition-specific program, the CCO must reassess the member for ICC services within seven calendar days of the transition and assign a new ICC care coordinator within three business days of the completion of the ICC reassessment;¶
(c) CCOs shall notify members of their ICC status by at least two means of communication within five business days following the completion of the ICC assessment. Notifications shall include details about the ICC program and the name and contact information of their assigned ICC care coordinator.¶
(11) CCOs shall implement procedures to share the results of ICC assessment including, without limitation, identifications made as a result of the assessment and Intensive Care Coordination Plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.607 and applicable state and federal privacy laws and meet timely access standards set forth in OAR 410-141-3515.¶
(12) ICC services shall include, without limitation:¶
(a) Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;¶
(b) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment

planning;¶
(c) Assistance to medical providers with coordination of capitated services and discharge planning; and¶
(d) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.¶
(13) ICC Care coordinators must provide the following services:¶
(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least once every three months and make other kinds of contact (face to face when possible) three times a month or more frequently if indicated. If an ICC care coordinator is unable to comply with the member contact requirements, the CCO must document attempts made, barriers, and remediation efforts taken to overcome the barriers to the member contact requirements;¶
(b) Contact the member no more than three calendar days after receiving notification of a reassessment trigger described in section (9) of this rule. If an ICC care coordinator is unable to make contact with the member within three calendar days of a reassessment trigger, the ICC care coordinator must document in the member's case file all efforts made to contact the member. ICC care coordinators must continue brief contacts with members who have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back to the routine contact requirements under subsection (a) of this section (13);¶
(c) Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care;¶
(d) Facilitate communication between and among behavioral and physical health service providers regarding 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. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;¶
(e) Convene and facilitate interdisciplinary team meetings monthly, or more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7). The ICC care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:¶
(A) Describe the clinical interventions recommended to the treatment team;¶
(B) Create a space for the member to provide feedback on their care, self-reported progress towards their ICC plan goals, and their strengths exhibited in between current and prior meeting;¶
(C) Identify coordination gaps and strategies to improve care coordination with the member's service providers;¶
(D) Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and¶
(E) Align with the member's individual ICC plan.¶
(f) Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.¶
(14) If a member is enrolled in other programs, including condition-specific programs, where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager shall be responsible for supporting specific needs based on their specialty within the interdisciplinary team.¶
(15) CCOs shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. CCOs shall produce ICC plans for each member requiring ICC services. Each ICC plan shall:¶
(a) Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTSS providers and the member's participation;¶
(b) Include consultations with any specialist(s) caring for the member and Medicaid funded long-term services and supports providers and case managers or for full benefit dual eligible (FBDE) members, Medicare providers or MCE aligned Medicare Advantage or Dual Special Needs Plan care coordinators;¶
(c) Be approved by the CCO in a timely manner if CCO approval is required;¶
(d) Be in alignment with rules outlined in OAR 410-141-3835 CCO Service Authorization; and¶
(e) Be in accordance with any applicable quality assurance and utilization review standards.¶
(16) CCOs shall periodically inform all participating providers of the availability of ICC and other support services available for members. CCOs shall also periodically provide training for patient-centered primary care homes and other primary care provider staff.¶
(17) CCO staff providing or managing ICC care coordination services shall be required to:¶
(a) Be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the CCO's service areas who are identified as being of a prioritized population;¶

~~(b) If a Member is unable to receive services during normal business hours, the CCO shall provide alternative availability options for the member;¶~~
~~(c) Be trained for, and exhibit skills in, person-centered care planning and trauma informed care; and communication with and sensitivity to the special health care needs of priority populations. CCOs shall have a written position description for its staff responsible for managing ICC services and for staff who provide ICC services;¶~~
~~(d) CCOs shall have written policies that outline how the level of staffing dedicated to ICC is determined. The ICC policies must include, without limitation, care coordination staffing standards such that the complexity, scope, and intensity of the needs of members receiving ICC services can be met.¶~~
~~(18) Consistent with the requirements under this rule, CCOs shall make Integration and Care Coordination services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a Member is unable to receive ICC services during normal business hours, the CCO shall provide alternative availability options for member to access services including Intensive Care Coordination Assessments and development of Intensive Care Coordination Plans.¶~~
~~(19) CCOs shall have a process to provide members with special health care needs who are receiving ICC services or are receiving Medicaid-funded LTSS with direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs. CCOs shall have processes in place to ensure it reviews member needs for LTSS and mechanisms to identify and refer to the Department of Human Services, inclusive of its Area Agency on Aging, Office of Developmental Disabilities Services (ODDS), and Aging and People with Disability (APD) programs, or, as may be applicable to a 1915(i) provider for LTSS assessment and service~~oordinated Care Organizations (CCOs) must ensure all services accessed by members are coordinated according to the needs of members, following the requirements in OAR 410-141-3860, OAR 410-141-3865 and in this rule.¶
(2) Upon enrollment, CCOs must act promptly to ensure services are coordinated for members needing Urgent Care Services as defined in OAR 410-120-0000(270) or Emergency Services as defined in OAR 410-120-0000(95), even if the member has not yet selected a Primary Care Provider (PCP) or completed a Health Risk Assessment (HRA).¶
(3) CCOs must formally designate a person or team as primarily responsible to coordinate services accessed by the member and must provide information to the member on how to contact their designated person or team.¶
(4) CCOs shall utilize a Care Profile for all members as defined in OAR 410-141-3500.¶
(a) The member Care Profile must identify:¶
(A) The member's identifying and demographic information;¶
(B) The member's communication preferences and needs (e.g. preferred language, method of communication, Alternate Formats, Auxiliary Aids and Services);¶
(C) The member's care team, along with their contact information, role, and any assigned Care Coordination Responsibilities. This must include, but is not limited to;¶
(i) The person or team formally designated by the CCO as primarily responsible for coordinating the services accessed by the member;¶
(ii) All providers serving the member, including, at minimum, their Primary Care Provider; and¶
(iii) The appropriate individuals from all entities serving the member, such as those listed in 410-141-3860(2). ¶
(D) The member's needs, goals and preferences determined on an initial and ongoing basis as described in OAR 410-141-3865;¶
(E) The member's health risk score and risk category as described in OAR 410-141-3860;¶
(F) Any open or closed Care Plans; and¶
(G) An overview of the supports, services, activities, and resources deployed to meet the member's identified needs.¶
(b) Upon a change in health-related circumstances, as described in OAR 410-141-3865(3)(g), the CCO must update the members Care Profile, determine if the development of a Care Plan is warranted and document the outcome and actions of the determination.¶
(5) CCOs must ensure services are actively coordinated for members when requested by the member, their representative or guardian, an involved provider or entity, or when required by the member's needs as identified in the members Care Profile. This coordination is accomplished through the development and implementation of a Care Plan that scales in complexity relative to the needs, goals, preferences, and circumstances of the member.¶
(a) CCOs shall consider the member's identified risk category to determine if a Care Plan is needed.¶
(A) Members in the no- or low-risk category do not require a Care Plan unless the member's needs change resulting in a higher risk category or when the member requests it;¶
(B) Members within the moderate-risk and high-risk categories must have a Care Plan developed.¶
(b) The Care Plan is developed, or revised as required in (5)(d) of this rule:¶

(A) In alignment with the member's needs, goals, preferences, and circumstances as detailed in the care profile;¶
(B) By incorporating information from any relevant assessments, treatment and service plans from providers involved in the member's care, and if appropriate and with consent of the member or the member's representative or guardian, information provided by community partners;¶
(C) In consultation with any other provider, case manager, or entity providing services to, or coordinating care for, the member;¶
(D) In consultation with a clinician that has the appropriate qualifications and clinical practice history to review and revise the Care Plan considering the members' complex physical, developmental, behavioral or dental health care needs;¶
(E) In accordance with a members updated risk level as described in (4)(a)(E) of this rule.¶
(F) With the member, their representative or guardians participation to the extent they desire or are able. The member, their representative or guardian may be satisfied with and understand the Care Plan, including any of their own roles and responsibilities.¶
(i) If participation in creating a member's Care Plan may be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a Care Plan;¶
(ii) The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to address the concern(s);¶
(iii) This decision must be reviewed prior to each significant Care Plan update resulting from a health-related circumstance change as set forth in OAR 410-141-3865(3)(g). The decision to continue the exclusion shall be documented.¶
(G) In accordance with state quality assurance and utilization review standards, as applicable.¶
(c) Upon completion of the Care Plan, CCOs must make it promptly available to the member, the members representative or guardian and to all relevant providers rendering services to the member who shall coordinate and provide services according to:¶
(A) The member, the member's representative or guardian must be provided immediate electronic access, or a copy in the member's preferred method of communication and in the member's preferred language. Auxiliary Aids and Services and Alternate Formats must be made available upon request of the member at no cost within five (5) business days of the request.¶
(B) If the CCO requires Care Plans to be approved, approval must be timely, according to a member's needs; and¶
(C) If providing the member with a copy of or access to their full Care Plan may be significantly detrimental to their care or health, as determined by the member's care team, CCOs may withhold from the member, only those parts of the plan that are determined to be detrimental. CCOs must document the reasons for withholding the full or partial Care Plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to address the concern(s). This decision to withhold the Care Plan in full or in part must be reviewed prior to each plan update, and the decision to continue withholding the Care Plan in full or in part shall be documented.¶
(d) Open Care Plans must be reviewed and revised at least annually, or¶
(A) When a member, member representative or guardian, or any provider serving the member requests a review and revision; or¶
(B) Upon a change in health-related circumstances as described in OAR 410-141-3865 (6)(g).¶
(e) The Care Plan may be closed and the member shall continue with Care Profile tracking only when;¶
(A) Requested by the member, their representative or guardian; or¶
(B) No longer warranted by the member's risk category or circumstances;¶
(C) There is no contact with the member, their representative or guardian after a minimum of three (3) attempts of outreach, utilizing at least two mixed modalities (e.g., telephonic, text, email, letter) over a sixty (60) day period , and with consultation and agreement of all available care team members.¶
(6) CCOs shall ensure Care Coordination for all members, regardless of where the member is receiving services.¶
(a) If members experience a Care Setting Transition CCOs must ensure:¶
(A) Members are transitioned into the most appropriate independent and integrated community settings and provided follow-up services as medically necessary and appropriate prior to discharge to facilitate successful handoff to community providers;¶
(B) Appropriate discharge planning and care coordination for adults who were members upon entering the Oregon State Hospital and who shall return to their home CCO upon discharge from the Oregon State Hospital;¶
(C) Coordination of care and discharge planning for out of service area placements, for which an exception shall be made to allow the member to retain Home CCO enrollment while the member's placement is a temporary residential placement as defined in OAR 410-141-3500, or elsewhere in accordance with OAR 410-141-3815. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan.¶
(b) Coordinate and authorize care when it has been deemed medically appropriate and medically necessary to

receive services outside of the service area because a provider specialty is not otherwise contracted with the;¶
(c) Coordinate the members care when they are temporarily outside their enrolled service area;¶
(d) If members are transitioning between CCOs or CCO to fee-for-service (FFS) as set forth in OAR 410-141-3850;¶
(e) Post Hospital Extended Care must be provided in accordance with OAR 411-070-0033:¶
(A) Post Hospital Extended Care Coordination (PHEC) is a twenty (20) day benefit included within the Global Budget and the CCO shall pay for the full twenty (20) day PHEC benefit when the full twenty (20) days is required by the discharging provider. CCOs shall make the benefit available to non-Medicare Members who meet Medicare criteria for a post-Hospital Skilled Nursing Facility placement. ¶
(B) CCOs shall notify the Member's local DHS APD office as soon as the Member is admitted to PHEC. Upon receipt of such notice, CCO and the Member's APD office must promptly begin appropriate discharge planning. ¶
(C) CCOs shall notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no less than two (2) full days prior to discharge. ¶
(D) CCOs shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to Durable Medical Equipment (DME), medications, home and Community based services, discharge education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to: ¶
(i) attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; or ¶
(ii) schedule follow-up care appointments with Providers that the Member may need to see; ¶
(iii) or both (i) and (ii). ¶
(E) CCOs shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at www.medicare.gov/publications ¶
(F) CCOs are not responsible for the PHEC benefit unless the Member was enrolled with the CCO at the time of the hospitalization preceding the PHEC facility placement.¶
(7) In addition to the care planning requirements above, for LTSS or Special Health Care Needs members as defined in OAR 410-141-3500 that are assessed according to OAR 410-141-3865(5) to have an ongoing special condition that requires a course of treatment or regular care monitoring or identified as high risk:¶
(a) CCOs must consider the above members, according to their needs, during Interdisciplinary Team Meetings which are convened and facilitated twice per month or more frequently, as needed, including a post-transition meeting of the interdisciplinary team within fourteen (14) days of a transition between levels, settings or episodes of care. These meetings must:¶
(A) Include the member, their representative or guardian, unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with (5)(b)(F) of this rule;¶
(B) Consider relevant information from all providers; and¶
(C) Provide a forum to:¶
(i) Describe the clinical interventions recommended to the treatment team;¶
(ii) Create a space for the member to provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meeting;¶
(iii) Identify coordination gaps and strategies to improve care coordination with the member's service providers;¶
(iv) Develop strategies to identify, monitor and follow up on needed referrals for specialty care, routine health care services (including medication monitoring), other community programs or social need services; and¶
(v) Align with and update the member's individual Care Plan and share the plan in accordance with (5)(c) of this rule. ¶
(b) CCOs must implement a mechanism to provide direct access to specialists, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685