

Jackson County
CCO 2.0 Provider Webinar

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Oregon Health Authority

Agenda

- 2020 member transition review and updates
- Member and provider communications
- Continuity of care
- Working with CCOs
- Changing plans in 2020
- How to help
- Q&A

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Member transition

Goals of CCO 2.0

Guiding values

2020 CCO changes

Goals of CCO 2.0

Guided by Governor Brown's vision, CCO 2.0 builds on Oregon's strong foundation of health care innovation.

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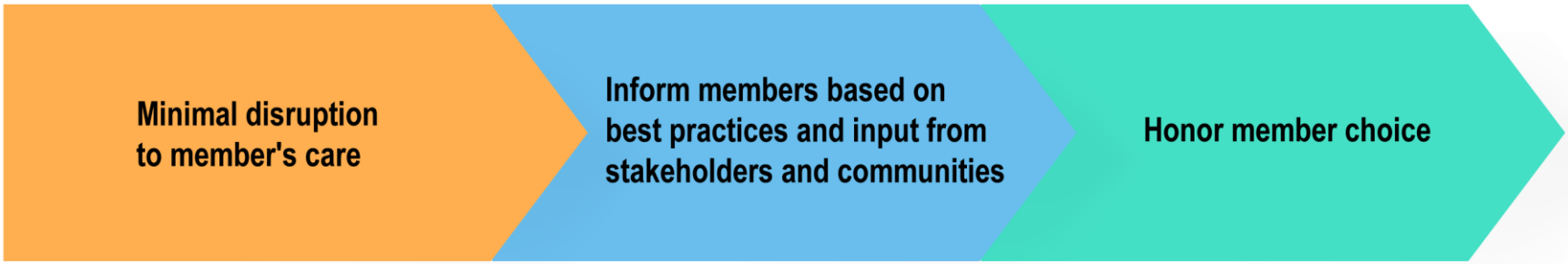
Guiding values for member transition



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2020 CCO changes: Josephine and Jackson Counties

CCO closures

- PrimaryHealth in Josephine, Jackson, and parts of Douglas counties

All former 1-year CCO contracts have been awarded 5-year contracts:

- AllCare Health, Cascade Health Alliance, Umpqua Health Alliance, Yamhill Community Care

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Provider network changes and member CCO reassignments

Due to changes in some CCOs' provider networks for 2020, OHA has reassigned some members to a different CCO than their original "match" to keep them with their current providers.

In Jackson County, network changes required OHA to match members to the CCO that works with their current providers.

- As a result, nearly 12,000 AllCare members were moved to Jackson Care Connect.

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CCO enrollment for special populations

Members in “special populations” were kept in the original CCOs they were enrolled in, unless effected by a CCO closure.

Special populations include:

- Members who are dually eligible for Medicare and Medicaid
- Members enrolled with the Office of Developmental Disability Services
- Children and youth enrolled in Child Welfare programs
- Children and youth enrolled in Oregon Youth Authority programs

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Guidance on communications and marketing to OHP members

If the member is not in the CCO you participate with:

- **Do not** use wording that urges or directly asks the member to change to that CCO.
  - Example: Choose CCO Y so you can get your care with Provider X
  - Printed material with such wording must be submitted by the CCO to OHA for review.
- **Do** use informational wording that lets members decide.
  - Example: Provider X is contracted with CCO Y.

If using OHA or “Pick Your Plan” images in material to members:

- Please make clear the document is not produced by OHA.

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Continuity of care

Timelines for CCOs and providers

Requirements for CCOs

Communicating CCO assignments

What providers should do

Timelines for CCOs and providers

OHA expects all CCOs and providers to follow this continuity of care guidance:

Up to **180** days

PRIOR AUTHORIZATIONS

- Honor approved PAs for up to 180 days or June 30, 2020, regardless of whether the provider is in network

90 days

PHYSICAL HEALTH PROVIDERS

- Members can see their current PCPs for 90 days or through March 31, 2020

180 days

BEHAVIORAL HEALTH PROVIDERS

- Members can see their current BH providers for 180 days or through June 30, 2020

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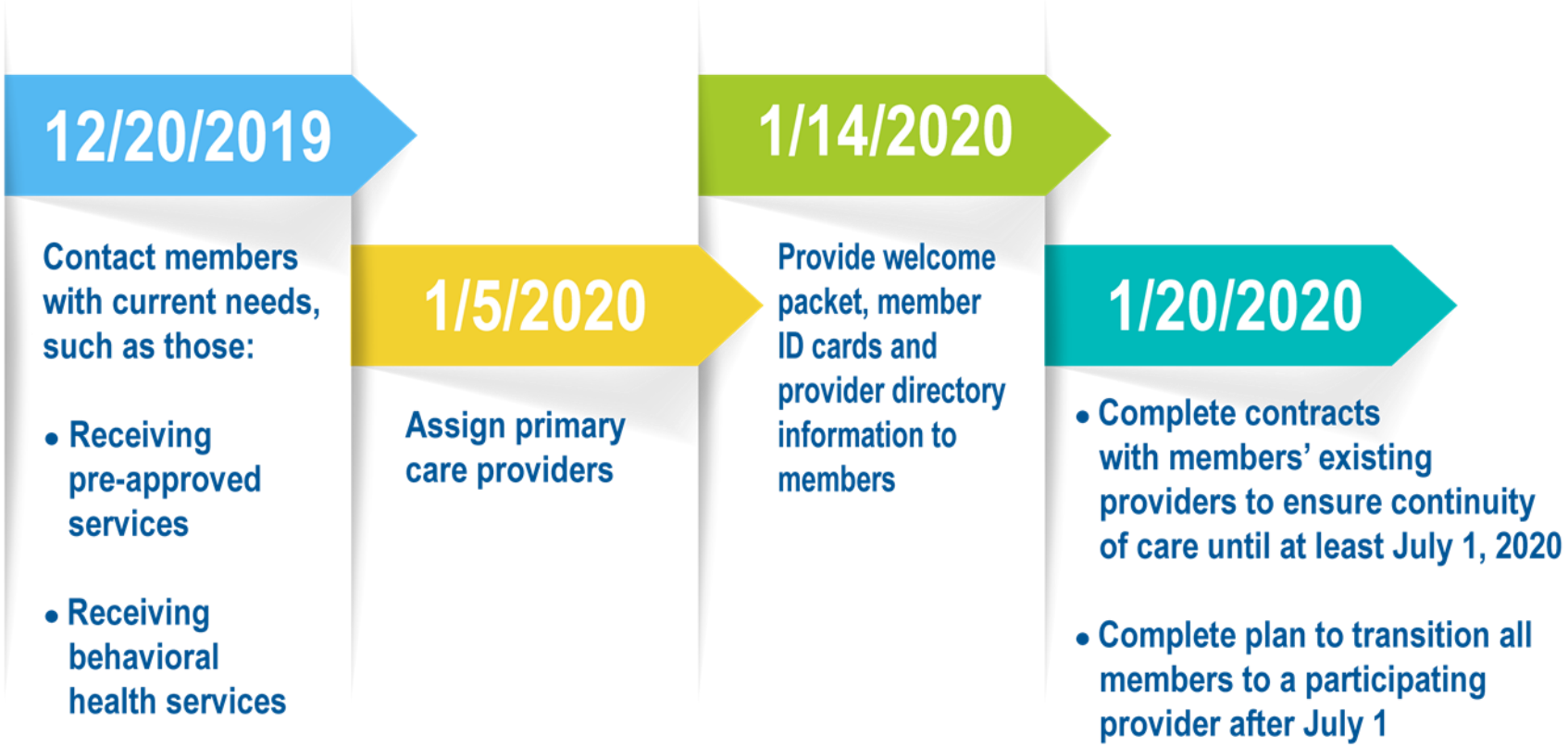
CCO contract requirements for Jan. 1 transition



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Communicating about CCO assignments

OHA sent CCOs final lists of their 2020 CCO members in December.

OHA cannot provide member lists to providers. Please contact your CCO to learn about the patients you will serve in 2020.

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Working with CCOs

Contracting

Billing and payments

Working with CCOs

- Consider joining the CCO's network or complete a single-case agreement with the patient's CCO to ensure continuity of care in 2020.
- Contact the CCO to learn about the systems, policies and procedures you will need to follow to get services approved and bill the CCO successfully.
- If you are not satisfied with a CCO's decision about provider participation or covered services:
  - Complete the CCO's appeal process, then
  - Request OHA review if necessary for resolution.

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Payments from CCOs

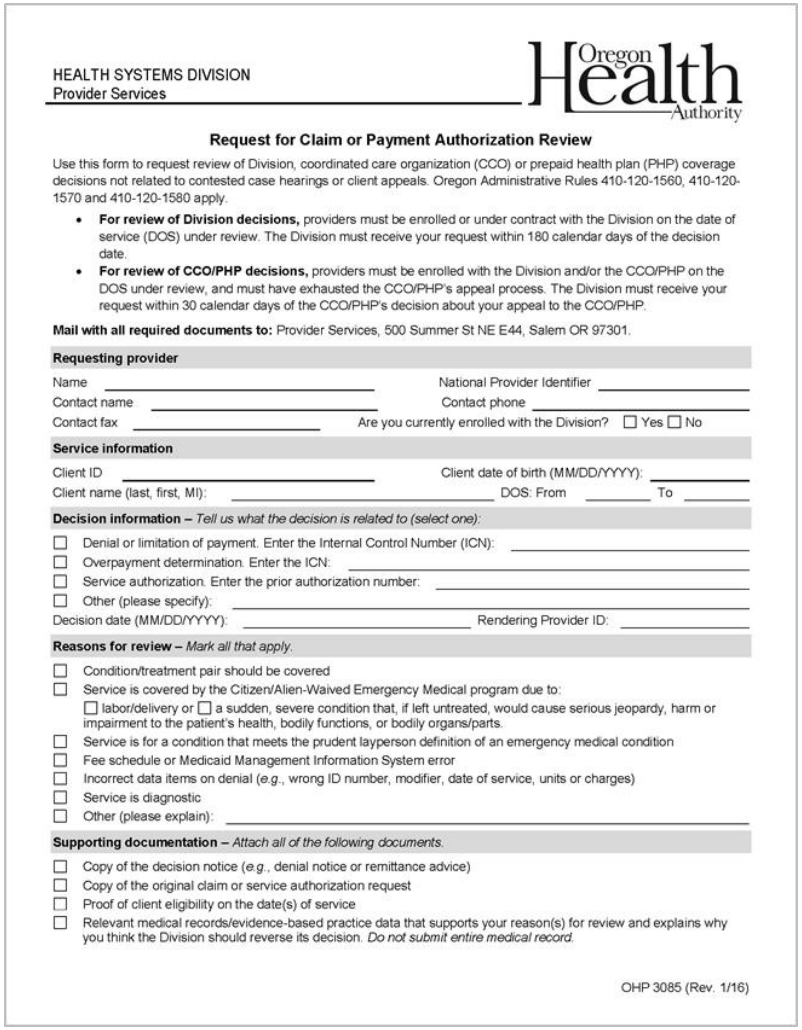
Payment is a matter between the CCO and provider.

CCOs must pay or deny at least:

- 90 percent of all valid claims within 30 days of receipt, and
- 99 percent within 90 days of receipt.

To dispute a payment decision:

- Follow the CCO's appeal process.
- If still in dispute, submit the OHP 3085 to OHA.



HEALTH SYSTEMS DIVISION
Provider Services

Oregon Health Authority

Request for Claim or Payment Authorization Review

Use this form to request review of Division, coordinated care organization (CCO) or prepaid health plan (PHP) coverage decisions not related to contested case hearings or client appeals. Oregon Administrative Rules 410-120-1560, 410-120-1570 and 410-120-1580 apply.

- **For review of Division decisions,** providers must be enrolled or under contract with the Division on the date of service (DOS) under review. The Division must receive your request within 180 calendar days of the decision date.
- **For review of CCO/PHP decisions,** providers must be enrolled with the Division and/or the CCO/PHP on the DOS under review, and must have exhausted the CCO/PHP's appeal process. The Division must receive your request within 30 calendar days of the CCO/PHP's decision about your appeal to the CCO/PHP.

Mail with all required documents to: Provider Services, 500 Summer St NE E44, Salem OR 97301.

Requesting provider

Name _____ National Provider Identifier _____
Contact name _____ Contact phone _____
Contact fax _____ Are you currently enrolled with the Division? ☐ Yes ☐ No

Service information

Client ID _____ Client date of birth (MM/DD/YYYY): _____
Client name (last, first, MI): _____ DOS: From _____ To _____

Decision information – *Tell us what the decision is related to (select one):*

☐ Denial or limitation of payment. Enter the Internal Control Number (ICN): _____
☐ Overpayment determination. Enter the ICN: _____
☐ Service authorization. Enter the prior authorization number: _____
☐ Other (please specify): _____
Decision date (MM/DD/YYYY): _____ Rendering Provider ID: _____

Reasons for review – *Mark all that apply.*

☐ Condition/treatment pair should be covered
☐ Service is covered by the Citizen/Alien-Waived Emergency Medical program due to:
☐ labor/delivery or ☐ a sudden, severe condition that, if left untreated, would cause serious jeopardy, harm or impairment to the patient's health, bodily functions, or bodily organs/parts.
☐ Service is for a condition that meets the prudent layperson definition of an emergency medical condition
☐ Fee schedule or Medicaid Management Information System error
☐ Incorrect data items on denial (*e.g.*, wrong ID number, modifier, date of service, units or charges)
☐ Service is diagnostic
☐ Other (please explain): _____

Supporting documentation – *Attach all of the following documents.*

☐ Copy of the decision notice (*e.g.*, denial notice or remittance advice)
☐ Copy of the original claim or service authorization request
☐ Proof of client eligibility on the date(s) of service
☐ Relevant medical records/evidence-based practice data that supports your reason(s) for review and explains why you think the Division should reverse its decision. *Do not submit entire medical record.*

OHP 3085 (Rev. 1/16)

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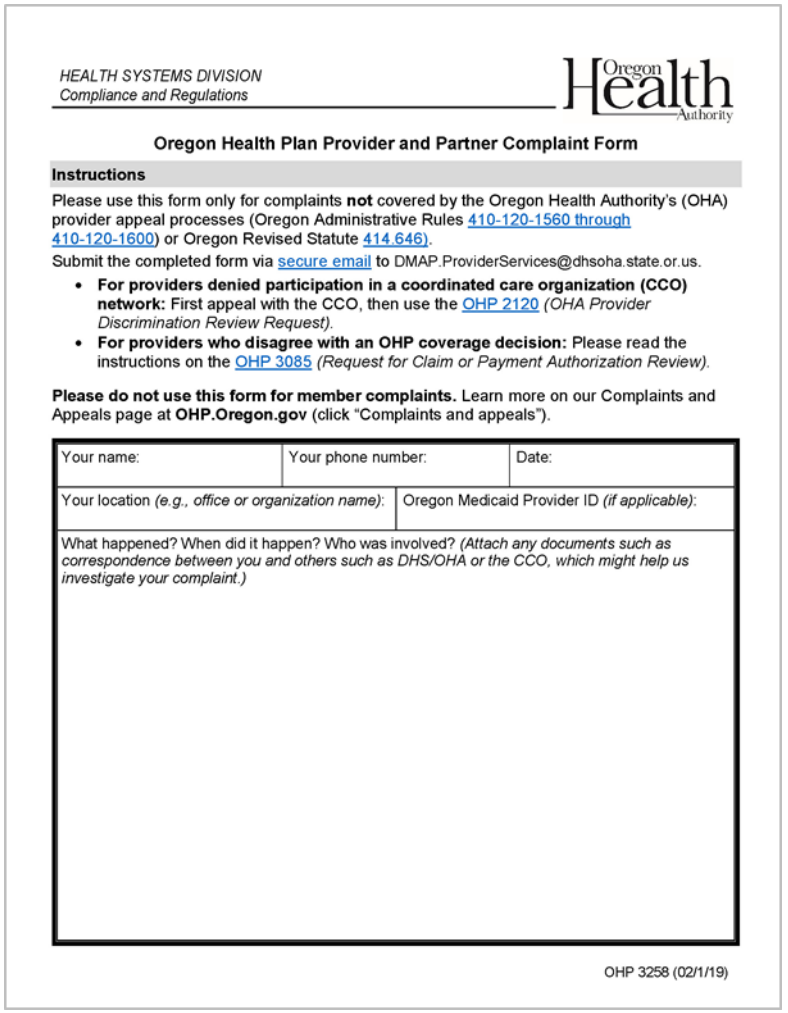
CCO payment – Transition of care

The CCO shall reimburse non-participating providers at no less than OHA's fee-for-service rates.

During the transition, CCOs must approve claims for covered services, even if they have no documented prior authorization.

Providers may negotiate with CCOs for a higher rate.

If you cannot agree on a rate, submit a complaint using the OHP 3258.



HEALTH SYSTEMS DIVISION
Compliance and Regulations

Oregon Health Authority

Oregon Health Plan Provider and Partner Complaint Form

Instructions

Please use this form only for complaints **not** covered by the Oregon Health Authority's (OHA) provider appeal processes (Oregon Administrative Rules 410-120-1560 through 410-120-1600) or Oregon Revised Statute 414.646).

Submit the completed form via secure email to DMAP.ProviderServices@dhsoha.state.or.us.

- **For providers denied participation in a coordinated care organization (CCO) network:** First appeal with the CCO, then use the OHP 2120 *(OHA Provider Discrimination Review Request).*
- **For providers who disagree with an OHP coverage decision:** Please read the instructions on the OHP 3085 *(Request for Claim or Payment Authorization Review).*

Please do not use this form for member complaints. Learn more on our Complaints and Appeals page at **OHP.Oregon.gov** (click "Complaints and appeals").

Your name:	Your phone number:	Date:
Your location *(e.g., office or organization name)*:	Oregon Medicaid Provider ID *(if applicable)*:	
What happened? When did it happen? Who was involved? *(Attach any documents such as correspondence between you and others such as DHS/OHA or the CCO, which might help us investigate your complaint.)*		

OHP 3258 (02/1/19)

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Changing plans

Jan. 1 through Mar. 31, 2020

Regular OHP process for changing plans

Changing CCOs from Jan. 1 through Mar. 31, 2020

- Members who **received letters** from OHA in December, can call OHP at **877-647-0027** or go to **bit.ly/ccochoice** to change CCOs.
- Members will need their OHP number to change plans.

Douglas County 97410 and 97442

- AllCare
- Umpqua Health Alliance

Douglas County 97424, 97436, 97493

- Trillium
- Umpqua Health Alliance

Jackson County

- AllCare
- Jackson Care Connect

Lane County

- PacificSource
- Trillium

Polk County 97101, 97304, 97347, 97371, 97378, 97396

- PacificSource
- Yamhill Community Care

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Timing of New CCO Enrollment

When a member chooses a new plan, their enrollment is updated using the “next weekly” schedule.

- Next weekly means that if members **make a choice by Wednesday**, their new plan would start the following Monday.
- If they **make a choice after Wednesday**, enrollment would not begin until one week from the following Monday.
- **After a change, OHP sends a letter with information about the new plan within two weeks.** This letter is called a coverage letter. The member’s new CCO plan will send a welcome letter with an ID card and a member handbook shortly after.
- Sometimes an enrollment can be completed faster due to medical need.

Regular process for changing CCOs

If they live in an area with more than one CCO, members can ask to change CCOs at other times, even if they were not part of the “Pick Your Plan” member choice period. Examples include:

- Within 30 days of initial enrollment, if enrolled in error
- Within 90 days of initial enrollment, for any reason
- After being enrolled for at least six months
- When renewing their OHP

To change CCOs:

- Members can call OHP Client Services at 800-273-0557 or submit a request at **ONE.Oregon.gov**.

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How to help

Supporting members

Medicare-Medicaid member information

Stay informed

What providers should do to support OHP members during this transition

Please assure patients that:

- Care will continue and their benefits remain the same.
- They should keep their appointments and continue to fill their prescriptions.

To support continued care during the transition, consider:

- Contracting with the member's new CCO or
- Completing a single-case agreement with the CCO.

Call CCO customer service lines for help or questions on member coverage. Do not tell patients to change appointments or turn them away. This is not acceptable.

Bill the CCO. Providers cannot bill members for services covered by Medicaid.

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Helping Medicare-Medicaid members

Remember:

- Most dual-eligible members were not part of the “Pick Your Plan” choice period.
- “Pick Your Plan” and the Jan. 1, 2020 transition only applies to Medicaid. It does not affect Medicare enrollment or plan choice.
- If they have Medicare as primary, they are not required to be in a CCO for physical health care.
- They can choose any Medicare plan they want or choose fee-for-service Medicare.
- Their local AAA/APD office will explain the options that work best for them.
- If a member has AllCare Medicare and Jackson Care Connect Medicaid, they can still see their existing PCP that does not contract with AllCare CCO.

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AllCare Care Coordination

- Approved authorizations will transfer with the member. This includes medications, referrals, surgeries, and DME
- NEMT rides will be covered by JCC and Translink
- January rides scheduled with ReadyRide before the transition will be provided by Translink
- Members and providers can call AllCare or JCC if they are unsure of what plan they are on. The CCOs will provide them information about which plan and NEMT vendor to contact.
- Members undergoing care coordination will be able to continue their case management under their new plan.

AllCare Care Coordination

If a provider has a member they are concerned about, please call AllCare at **541-471-4106** and request **Care Coordination Services**.

We can provide the member with a warm hand-off to JCC.

The single biggest take away we would like to impart:

- It will take some time to get authorizations transferred from AllCare system into JCC's.
- All of those authorizations will be honored.
- **Please do not turn members away!**

Jackson Care Connect Coordination

Customer Service phone number: 855-722-8208

Care Coordination - Regional Care Team

Email: ccreferral@careoregon.org or Phone: 503-416-3742

Members: Call Customer Service to change Primary Care Providers

Questions regarding member written communication?
Please email kingcoles@careoregon.org

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Q&A

OHA:

David Baden, Chief Financial Officer
Lori Coyner, Sate Medicaid Director

AllCare:
Shelia Anders
Will Brake

Jackson Care Connect:
Tracy Muday
Darin Brink
BingBing Liang
San Sunowen
Danielle Barzaga

How to stay informed

OHP provider website

CCO 2.0 website

Provider Matters newsletter

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