Lane County
CCO 2.0 Provider Webinar

Lori Coyner, State Medicaid Director

David Baden, Chief Financial Officer

February 25, 2020

Oregon Health Authority

Agenda

2020 member transition review and updates

Continuity of care

How to help members during the transition

Care coordination information

- Trillium Community Health Plan
- PacificSource Community Solutions

Q&A

Member Transition

Goals of CCO 2.0

Guiding values

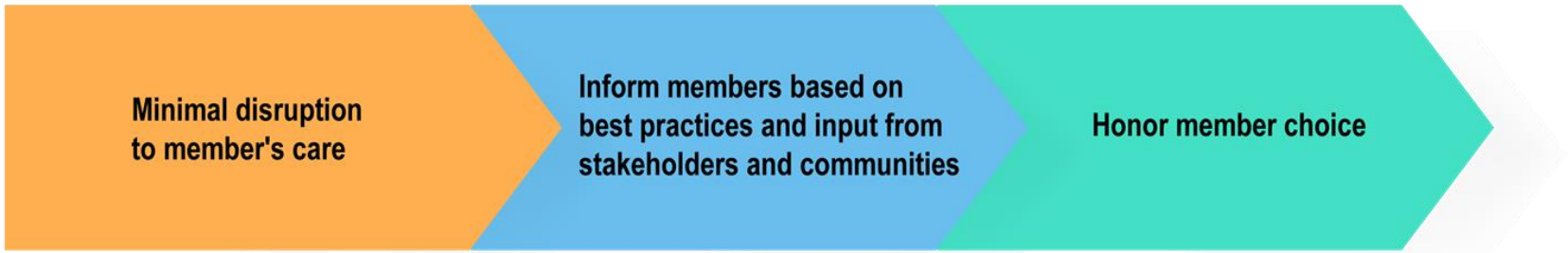
2020 CCO changes

Goals of CCO 2.0

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

Oregon Health Authority

Guiding values for member transition



2019 member allocation process

In August 2019, OHA matched members to Trillium or PacificSource as their 2020 CCO based on many factors such as:

- Primary care and behavioral health services billed for the member in the previous 24 months
- Keeping family members in the same CCO

This resulted in 29,000 members scheduled to move to PacificSource.

In October, network changes required OHA to do a new allocation to assign members to the CCO that works with their providers. As a result:

- OHA identified 45,000 Trillium members to move to PacificSource.
- This is an additional 16,000 since August.

Current membership between the two CCOs is 55,500 to PacificSource and 36,500 to Trillium.

CCO enrollment for special populations

There were 19,860 special population members in Lane County. Special populations include members who are:

- Dually eligible for Medicare and Medicaid
- Enrolled with the Office of Developmental Disability Services
- Enrolled in Child Welfare programs
- Enrolled in Oregon Youth Authority programs

To maintain continuity of care, these members stayed enrolled with their existing (2019) plan for 2020.

- For most members, the existing plan was Trillium.
- Some members may have had a different plan due to service area exceptions or other special considerations.

Continuity of Care

Timelines for CCOs and providers

Requirements for CCOs

CCO billing and payments

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

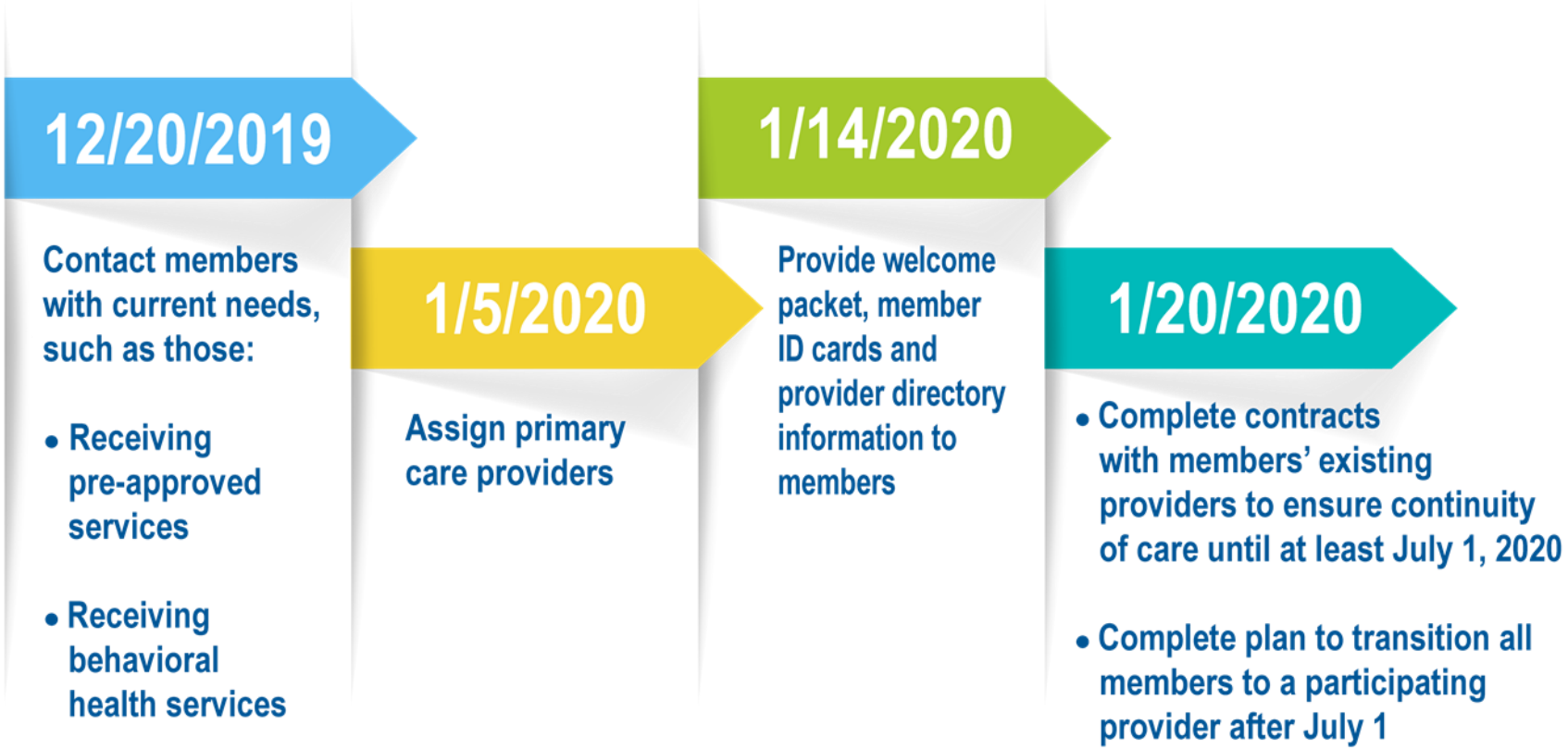
180 days

BEHAVIORAL HEALTH PROVIDERS

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

Oregon Health Authority

CCO contract requirements for Jan. 1 transition



Oregon Health Authority

Working with CCOs

- 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 sure if you should or can see a specific member, contact the member's CCO to get help coordinating care.
- 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.

Payments from CCOs

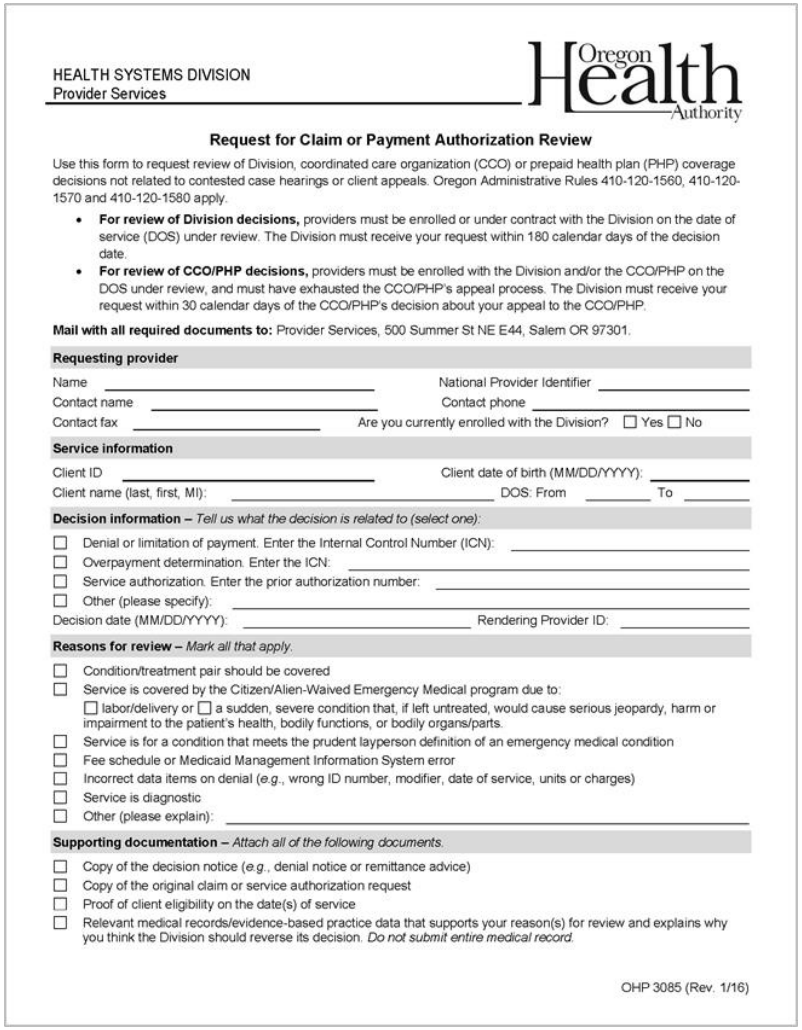
Payment is a matter between the CCO and provider.

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)

Oregon Health Authority

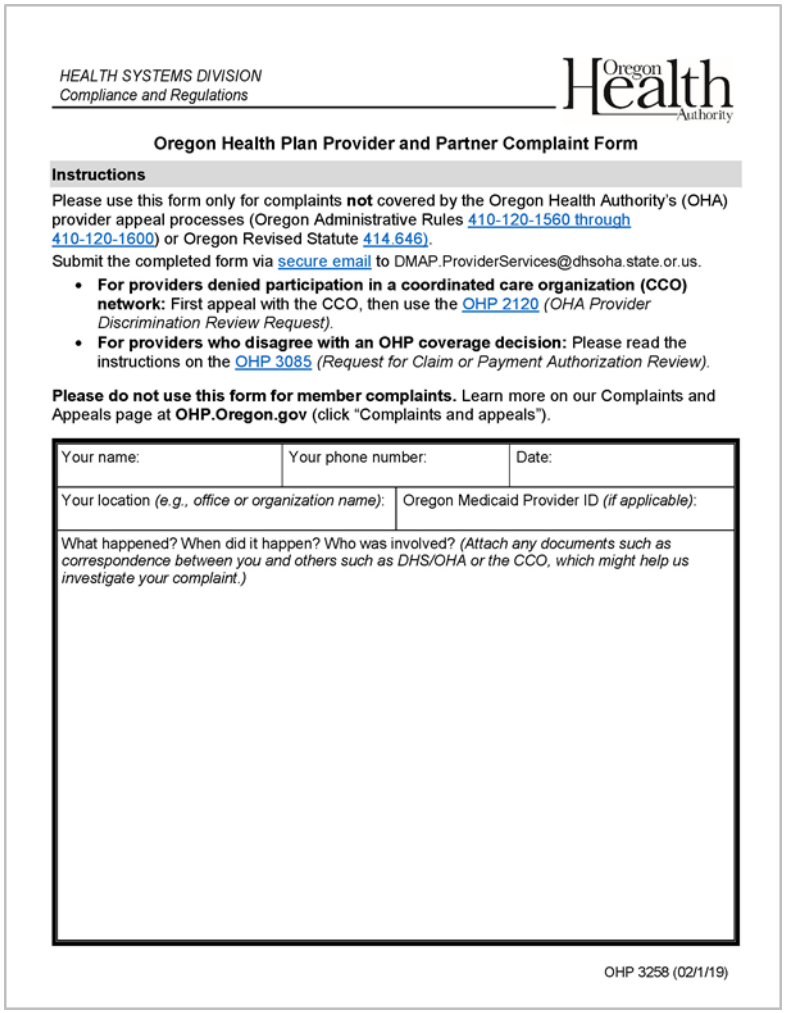
CCO payment – Transition of care

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)

Oregon Health Authority

How to Help

Telling members about the CCOs you work with

Supporting members

Medicare-Medicaid member information

How members can change CCOs

Telling members about the CCOs you work with

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

- **Do** use informational wording that lets members decide.
  - Example: Provider X is contracted with CCO Y.
- **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.

How to support OHP members

Please assure patients that:

- Care will continue and their benefits remain the same.
- They should keep their appointments and 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, available providers and Primary Care Provider (PCP) assignments. 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.

Helping Medicare-Medicaid members

Remember:

- Most dual-eligible members **did not** change plans on Jan. 1.
- 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.

How members can change 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**.
- Members will need their OHP number to change plans.

After Mar. 31, 2020:

- Members can call OHP Client Services at 800-273-0557 or submit a request at **ONE.Oregon.gov**.
- Members can change CCOs at other times, such as:
  - 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

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.
- Sometimes an enrollment can be completed faster due to medical need.

Once the enrollment change is made:

- OHP sends a letter with information about the new plan within three to four business days. 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 within two weeks.

Care Coordination

Trillium Community Health Plan

PacificSource Community Solutions

Trillium Community Health Plan

Approved authorizations will transfer with the member.

- This includes medications, referrals, surgeries, and DME.

NEMT rides will be covered by RideSource.

Members and providers can call either CCO if they are unsure of what plan they are on.

- The CCOs will provide information about which plan to contact.

Members undergoing care coordination will be able to continue their case management under their new plan.

- Regarding claims payment, we will honor transition of care rules.

Call Trillium directly with any concerns:

- 541-485-2155 or 1-877-600-5472.

Trillium Care Coordination

If a provider has a member they are concerned about:

- Please call Trillium at 541-485-2155 or 1-877-600-5472.
- We can provide the member with a warm hand-off to PacificSource.

The single biggest take away we would like to impart:

- It will take some time to get authorizations transferred.
- All of those authorizations will be honored.
- **Please do not turn members away!**

PacificSource Community Solutions

Approved authorizations will transfer with the member.

- This includes pharmacy, behavioral health, specialty referrals, surgeries, and DME.

NEMT rides will be covered by RideSource.

Members and providers should call PacificSource to verify enrollment.

- We will provide information about participating providers, PCP assignment and transitions of care.

Members undergoing care coordination will be able to continue their care management under their new plan.

PacificSource Care Coordination

If a provider has a member who needs care management:

- Please call PacificSource at 541-330-2507 or 1-888-970-2507 and request **Care Management**.

All authorizations from the member's previous CCO will be honored.

- Providers may reach out to our **Utilization Management Department** for questions related to prior authorizations at 541-330-7301.
- For pharmacy authorizations, providers should call 541-330-2467 or 1-855-228-6229.

Thank you for serving our members in Lane County and helping them get the care they need!

PacificSource Community Solutions

Customer Service (including PCP assignment or provider participation)

Email: CommunitySolutionsCS@PacificSource.com

Phone: 1-800-431-4135 or 503-210-2515

Care Management

Email: MedicaidMSS@PacificSource.com

Phone: 541-330-2507 or 1-888-970-2507

Utilization Management

Email: MedicaidUMHSR@PacificSource.com

Phone: 541-330-7301

Members should call Customer Service to change Primary Care Providers.

Q&A

OHA:

David Baden, Chief Financial Officer

Lori Coyner, State Medicaid Director

Trillium CHP:

Christopher Hummer, CEO

Justin Lyman, CFO

Jeanne Savage, CMO

Amanda Cobb, Executive Director of Medicaid

PacificSource Community Solutions:

Jane Hannabach, VP of Government Operations

Sara Ohrtman, Director of Provider Network

How to stay informed

OHP provider website

CCO 2.0 website

Provider Matters newsletter

@OregonHealthAuthority

@OHAOregon

Oregon Health Authority

Oregon Health Authority