Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: CM-004	**TITLE:** Care Coordination
DEPARTMENT: Care Management	**APPROVED BY:** Chief Medical Officer & President/CEO
EFFECTIVE DATE: 02/15/2017	**LAST REVISION DATE:** 09/06/2024
REVIEW DATES: 01/22/2021, 02/27/2022	
APPLIES TO: Yamhill Community Care, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Aging and People with Disabilities (APD)	The division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD).
Care Coordination	Act and responsibility of care coordination entities to deliberately organize culturally and linguistically appropriate member services, 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 Coordinator	A single, consistent individual who: a. is familiar with a member's history, strengths, needs, support system, providers, and legal status, and b. the systems with which a member is involved, follows a member through transitions in levels of care, is responsible for taking a system-wide view to ensure services are unduplicated and consistent with member's identified strengths and needs, is responsible for ensuring that participants involved in a member's care coordination facilitate the appropriate health care services and support activities, and fulfills the care coordination standards identified in the OHP Health Plan Services contract.
Care Profile	Electronic record YCCO develops and maintains for all members. 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 YCCO outreach and care coordination activities/opportunities that shall be offered to the member. Care profile requirements are further

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	described in the policy below and in OAR 410-141-3865 and 410-141-3870.
Case Management Services	services provided to ensure that YCCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.
Child Welfare (CW)	Division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.
Community Health Worker (CHW)	Individual who has expertise or experience in public health; works in urban or rural community in association with a local health care system; to the extent practicable, shares ethnicity, language, socioeconomic status and life experience with the residents of the community served; assists member to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; provides health education and information that is culturally appropriate to the members being served; assist member is receiving the care they need; may give peer counseling and guidance on health behaviors and may provide direct services such as first aid or blood pressure screening.
Community Integration Manager (CIM)	A Multi-tenant platform designed to perform core health plan administrative functions including provider reimbursement, utilization management, member enrollment and customer service.
Community Mental Health Program (CMHP)	Organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.
Condition Specific Program or Facility	Programs or facilities that treat a narrowly defined illness, disorder or condition, such as: behavioral and mental health conditions, substance use disorder (SUD) or addiction, including but not limited to; alcohol; illicit drugs; and gambling. Physical health conditions, including but not limited to: cancer; diabetes; bariatric care; or developmental disabilities.
Coordinated Care Organization (CCO)	A corporation, governmental agency, public corporation, or other legal entity this is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.
Dual Special Needs Plan (D-SNP or DSN Plan)	Medicare Advantage plan that limits enrollment to Medicare beneficiaries who meet certain eligibility criteria, these plans serve people who have both Medicare and Medicaid benefits.

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Emergency Services	Health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.
Exceptional Health Care Needs (EHCN)	Members identified as aged, blind, or disabled who have complex medical needs.
Full Benefit Dual Eligible (FBDE) or Fully Dual Eligible	For the purpose of Medicare Part D coverage, Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
Health Risk Assessment (HRA)	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 (including Health Related Social Needs and Social Determinants 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.
Home and Community Based Services (HCBS) Waiver	States can provide specific employment supports to individuals through Home and Community Based Services (HCBS) under Section 1915(c) waivers or Section 1915(i) state-plan services 1915(c) waivers provide long-term care for individuals who would receive institutional care without a waiver. 1915(i) services provide HCBS to individuals who meet state-defined criteria.
Home Coordinated Care Organization (CCO)	The CCO enrollment situation that existed for a member prior to placement, including services received through Oregon Health Plan (OHP) fee-for-service, based on permanent residency.
Intellectual and Developmental Disabilities (IDD or I/DD)	Intellectual and developmental disabilities (IDDs) are disorders that are usually present at birth and that negatively affect the trajectory of the individual's physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems.
Institution for Mental Diseases (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient 7 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.
Long-Term Care Services and Supports (LTSS)	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 and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.
Managed Care Entity (MCE)	Entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
Medicaid Fee For Service (FFS)	OHP enrollees that receive care from the state vs a CCO and the state directly pays providers for the covered services they receive.
Medically Fragile Children (MFC)	Children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, have been found eligible for MFC services by the Department of Human Services.
Medicare Advantage (MA)	Type of Medicare health plan offered by a private company that contracts with Medicare. Medicare pays the premiums for participants in Medicare Advantage plans.
Non-Emergent Medical Transportation (NEMT)	Transportation to or from a source of covered service, which does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.
Oregon Youth Authority (OYA)	State department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.
Participating Practitioner/Provider	A licensed practitioner or provider that is participating in the YCCO and subcontractor provider network.
Patient Centered Primary Care Home (PCPCH)	Health care clinic that has been recognized for their commitment to patient-centered care. In a Patient-Centered Primary Care Home, the patient is the most important part of the care. The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of care. The program is part of the Oregon Health Authority and one of the many efforts to help improve the health of all Oregonians and the care they receive.
Prioritized Populations	Individuals who: are older adults; individuals who are hard of hearing, deaf, blind, or have other disabilities; individuals that have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded LTSS; children ages 0-5 showing early signs or social/emotional or behavioral problems, or who have SED diagnosis; individuals who

	are in medication assisted treatment for SUD; individuals who have been diagnosed with a high-risk pregnancy; children with neonatal abstinence syndrome; children in Child Welfare; individuals who are IV drug users; people with SUD in need of withdrawal management; people who have HIV/AIDS or who have tuberculosis; veterans and their families; individuals who are at risk of first episode psychosis; and individuals within the IDD populations.
Provider Network (Delivery System)	Participating providers affiliated with the CCO who are authorized to provide services to its members.
Urgent Care Services	Health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.
Serious and Persistent Mental Illness (SPMI)	Group of severe mental health disorders as defined in the Diagnostic and Statistical Manual (DSM) used by mental health professionals to diagnose. The SPMI category includes major depression, bipolar disorders, schizophrenia, and borderline personality disorder.
Severe Emotional Disturbance (SED)	Children or persons under the age of 18, who have diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with DSM-V that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Special Health Care Needs (SHCN)	Members who have health care needs, multiple chronic conditions, mental illness, or Substance Use Disorders and either:
	I. Have functional disabilities,
	II. 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
	III. Are a Prioritized Population member. This included members who:
	• Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;
	• 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);
	• Are children ages 0-5:
	  ○ Showing early signs of social/emotional or behavioral problems; or
	  ○ Have a Serious Emotional Disorder (SED) diagnosis.
	• Are in medication assisted treatment for SUD;
	• Are women who have been diagnosed with a high-risk pregnancy;
	• Are children with neonatal abstinence syndrome;
	• Children in Child Welfare;

	• Are IV drug users; • People with SUD in need of withdrawal management; • Have HIV/AIDS or have tuberculosis; • Are veterans and their families; • Are at risk of first episode psychosis; Individuals within the Intellectual and developmental disability (IDD) populations.
Social Determinants of Health and Equity (SDOH-E)	SDOH-E encompasses three terms: • The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities; • The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities; • Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity. • SDOH-E initiatives may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including: o Community-level interventions that directly address social determinants of health or social determinants of equity; Interventions to address individual health-related social needs.
Specialty Providers (Specialist)	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.
Subcontractor	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.
Substance Use Disorder (SUD)	Drug addiction, a disease that affects a person's brain and behavior and leads to the inability to control the use or a legal or illegal drug or medication.
Traditional Health Worker (THW)	Umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The 5 types of Traditional Health Workers: - Birth Doula, - Personal Health Navigator (PHN), - Peer Support Specialists (PSS), - Peer Wellness Specialist (PWS) and Community Health Workers (CHW).

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Transition of Care Period	The period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services.

POLICY:

Yamhill Community Care (YCCO) and subcontractors comply with all applicable federal and state contractual rules and regulations.

YCCO provides members integrated person-centered care and services, assuring that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations member when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. The coordination will 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).

YCCO member's privacy will be protected throughout the care coordination process including allowing access to, and the ability to share, protected health information with other involved in their care per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 164, Subpart A and E. YCCO will provide coordination and transition in a manner that is medically appropriate, trauma-informed, linguistically, and culturally appropriate. All coordination activities will be completed in accordance with 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.

YCCO has mechanisms in place to identify the member's physical, developmental, behavioral, dental, and social needs (including HRSN and SDOH-E, goals, and preferences of members on an initial and ongoing basis.

Health Risk Assessments (HRA) are available to members, their representative or guardian orally, in writing, or online. HRAs are available in the language the member prefers and in large print.

PROCEDURE:

Upon enrollment YCCO will act promptly to ensure services are coordinated for members needing urgent care services or emergency services even if the member has not yet selected a PCP or completed an HRA.

YCCO has designated individuals and/or teams that are primarily responsible to coordinate services accessed by the member and will provide information to the member on how to contact their designated individual or team.

Care Profiles

YCCO uses a care profile for all members 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 YCCO outreach and care coordination activities/opportunities that shall be offered to the member.

The care profile identifies the following:

1. The member's identifying and demographic information;
2. The member's communication preferences and needs (preferred language, method of communication, alternate formats, auxiliary aids and services);
3. 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;

a. The person or team formally designated by the CCO as primarily responsible for coordinating the services accessed by the member;
b. All providers serving the member, including, at minimum, their PCP; and
c. The appropriate individuals from all entities serving the member, such as Medicaid FFS, Medicare or Medicare Advantage plans, Community Mental Health Programs (CMHP), Oregon Department of Human Services (ODHS) also including Aging People with Disabilities (APD), Child Welfare (CW), 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.

4. The member's needs, goals and preferences determined on an initial and ongoing basis (physical, developmental, behavioral, dental, and social needs including HRSN and SDOH-E);
5. The member's health risk score and risk category low risk, moderate risk, and high risk used to inform the level of intensity and intervention required by the member (OAR 410-141-3860) See Risk Stratification section;
6. Any open or closed Care Plans; and
7. An overview of the supports, services, activities, and resources deployed to meet the member's identified needs.

Risk Stratification

Pending OHA risk stratification model approval, YCCO will utilize John's Hopkins' Risk Stratification Tool "ACG" to stratify members into six different Resource Utilization Bands (RUBs) as follows:

- 0 - No or Only Invalid Dx
- 1 - Healthy Users
- 2 - Low
- 3 - Moderate
- 4 - High
- 5 - Very High

Risk stratification will be run monthly to determine current and rising risk scores. These risk scores will be imported into Helios Care Management System and updated monthly. In addition, historic trends will be tracked, and members who move to a greater RUB will be monitored for eligibility for Care Management outreach. Possible future interventions may include telephonic outreach (robocalling), electronic communication such as text messages, or periodic post card campaigns to let members know that care management help is available to them and other possible methods to be determined.

Within 90 days or sooner or upon change in health related circumstances as indicated by a rising RUB, YCCO will update the members care profile, determine if the development of an initial needs identified care plan is warranted due to a member rising from a low to moderate or high RUB and document the outcome and actions of the determination. Change in health-related circumstances are defined but not limited to any of the following occurrences:

- Hospital ER visits, hospital admissions or discharges;
- Mobile Crisis response;
- Pregnancy diagnosis;
- Chronic disease diagnosis;
- Behavioral health diagnosis;
- Intellectual/Developmental Disability (I/DD) diagnosis;
- Event that poses a significant risk to the member that is likely to occur or reoccur without intervention;
- Recent, or at risk for, homelessness or non-placement;
- Two or more billable primary ICD-10 Z code diagnoses within one (1) month;

- Two or more caregiver placements within past six (6) months;
- Discharge from a correctional facility, juvenile detention facility, other residential or long-term care settings back to the community or another care setting;
- Exit from Condition Specific Program or Facility as defined in OAR 410-141-3500;
- Enrollment or disenrollment in other service programs such as Long-Term Services and Supports, Intellectual/Developmental Disability services or Children's Intensive In-home services;
- Orders for Home Health or Hospice services;
- Newly identified or change to an identified Health Related Social Need (HRSN);
- An identified gap in network adequacy that leaves the member without a needed service or care;
- Life span developmental transitions such as a transition from pediatric to adult health care;
- Entry into, or change of placement while in, foster care.

See CM Risk Stratification Workflow

Care Plan

YCCO ensures services are actively coordinated for members when requested by the member, their representative or guardian, or 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 member's needs, goals, preferences, and circumstances.

YCCO considers the members identified risk category to determine if a care plan is needed.

- No or low risk – member does not require a care plan, unless the member's needs change resulting in a higher risk category or when the member request it.
    - If the member is engaged with CM with a no or low risk score, a manual complete care plan will be created with member participation including identified goals and interventions.
- Moderate and high risk – member requires an initial needs identified care plan be developed for those members not engaged with CM.
    - For members who are engaged with CM, a full care plan will be developed in partnership with the member, including goals and interventions.
    - If the member is not engaged in CM, the member will have a system generated care plan with initial needs identified (needs CM outreach and/or screening).

Care Plan Requirements:

1. The plan is in alignment with the member's needs, goals, preferences, and circumstances as detailed in the care profile;
2. Incorporates 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;
3. In consultation with any other provider, case manager, or entity providing services to, or coordinating care for, the member;
4. The clinician or consultation with a clinician that has the appropriate qualifications and clinical practice history to review and revise the plan considering the members' complex physical, developmental, behavioral or dental health care needs;
5. In accordance with a members updated risk level of no, low risk, moderate risk, or high risk.
6. The member, their representatives or guardians participate 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.
    a. When participating in creating a member's 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 plan development;
    b. YCCO will 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);
    c. This decision must be reviewed prior to each significant plan update resulting from a health-related circumstance change above. The decision to continue the exclusion will be documented.
7. In accordance with state quality assurance and utilization review standards, as applicable.
8. Upon completion of the plan, YCCO will 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:
9. 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.
10. When YCCO requires Care Plans to be approved, approval must be timely, according to a member's needs; and
11. When 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, YCCO may withhold from the member, only those parts of the plan that are determined to be detrimental. YCCO will document the reasons for withholding the full or partial 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 plan in full or in part must be reviewed prior to each plan update, and the decision to continue withholding the plan in full or in part shall be documented.

Care Plan Development, Review and Revision:

- *Initial needs identified care plans may be system generated upon receiving a moderate or high-risk score. This may also be manually generated at the time of initial engagement with CM RN.*
- *Full care plans for engaged CM members which includes member participation to develop goals and interventions will be done as soon as possible pending member availability after the completion of either the HRA or any other condition specific assessment by the CM RN.*
- Care plans must be reviewed and revised at least annually, or:
- When a member, member representative or guardian, or any provider serving the member requests a review and revision; or
- Upon a change in health-related circumstances listed above indicated by a rising RUB; or
- For members with a rising risk score going from low to moderate, or moderate to high (based on the monthly Tableau report) a system generate initial needs identification will be produced. For members who are involved with CM, their care plan will be updated with appropriate update to needs, goals, and interventions.

Care plan may be closed, and the member shall continue with care profile tracking only when:

- Member, their representative or guardian; or
- No longer warranted by the member's risk category or circumstances; or
- There is no contact with the member, their representative or guardian after a minimum of 3 attempts of outreach, utilizing at least 2 missed modalities (telephone, text, email, letter) over a 60-day period, and with consultation and agreement of all available care team members.

Care Setting Transition

YCCO ensures care coordination for all members, regardless of where the member is receiving services.

If a member experiences a care setting transition YCCO ensures:

1. 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;
2. 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;
3. Coordination of care and discharge planning for out of service area placements, for which an exception will be made to allow the member to retain home CCO enrollment while the member's placement is a temporary residential placement, or elsewhere in accordance with OAR 410-141-3815. YCCO prior to discharge, coordinate care in accordance with a member's discharge plan.
    a. 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 YCCO.
    b. Coordinate the members care when they are temporarily outside their enrolled service area;
    c. If members are transitioning between CCOs or CCO to FFS see Transition of Care section;
    d. Post hospital extended care will be provided see Post Hospital Extended Care benefit section;
4. Post hospital extended care coordination (PHEC) is a 20-day benefit included within the Global Budget and YCCO will pay for the full 20-day PHEC benefit when the full 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.
5. YCCO will notify the member's local DHS APD office as soon as the member is admitted to PHEC. Upon receipt of such notice, YCCO and the member's APD office must promptly begin appropriate discharge planning.
6. YCCO will notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no less than 2 full days prior to discharge.
7. YCCO will 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:
    a. Attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; or
    b. Schedule follow-up care appointments with Providers that the Member may need to see;
    c. Or both a and b.
8. YCCO will 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.
9. YCCO is 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.

See CM Workflow RN Care Manager Post Inpatient Follow Up

Long Term Services and Supports (LTSS) and Special Health Care Needs (SHCN) Members
In addition to care planning requirements above LTSS and SHCN members are assessed to have an ongoing special condition that requires a course of treatment or regular care monitoring or identified as high risk:

- YCCO will 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 14 days of a transition between levels, settings or episodes of care.

Interdisciplinary Team Meetings

The interdisciplinary team meetings will:

1. 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:
2. Consider relevant information from all providers; and
3. 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 Care 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 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
    e. Align with and update the member's individual Care Plan and share the plan as required.
4. YCCO will 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.

See CM Workflow Health Services Specialist (HSS) MDT meeting

Direct Access

YCCO has a mechanism to provide direct access to specialist (no referrals are required for in-network providers) and will use a standing referral is the provider requires it or an approved number of visits, as appropriate for the member's condition and identified needs.

Enrollment

CCO Enrollment for Temporary Out of Area Behavioral Health Services

1. The Authority has determined that, to the maximum extent possible, all individuals shall be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. OAR 410-141-3815 implements and further describes how the Authority administers its authority under OAR 410-141-3805 and OAR 410-141-3810 for purposes of making enrollment decisions for adult and young adult individuals, 14 through and including 17 years of age, receiving temporary out-of-area behavioral health treatment services:
    a. For program placements in Child Welfare, Behavioral Rehabilitative Services, Oregon Youth Authority, and Psychiatric Residential Treatment Services,(OAR 410-141-3800 contains program-specific rules);
    b. For program placements in Secure Children's In-Patient (SCIP) and Secure Adolescent In-Patient (SAIP), YCCO will work with the Authority in managing admissions and discharges;
    c. The member will remain enrolled with YCCO for delivery of SCIP and SAIP services. YCCO will bear care coordination responsibility for the entire length of stay, including admission, determination, and planning.
2. Specific to residential settings specializing in the treatment of SUD, if the individual is enrolled in YCCO or FFS on the same day the individual is admitted to the residential treatment services, YCCO or FFS shall be responsible for the covered services during that placement even if the location of the facility is outside of YCCO's service area. Upon discharge, FFS members shall, upon the next available enrollment date, enroll

with the CCO that is contracted for their residential service area.

3. Home CCO assignment is based on the member's residence. Home CCO enrollment for temporary out-of-area placement shall:
    a. Meet Oregon residency requirements (OAR 410-200-0200);
    b. Comply with the CCO enrollment rules (OAR 410-141-3805);
    c. Be based on most recent permanent residency and related CCO enrollment history prior to temporary placement. If the client has no enrollment history, new enrollment shall reflect most recent permanent residence prior to hospital, institutional, and residential placement; and
    d. Be consistent with OAR 410-141-3810 when the client exercises recipient choice, where the client is able to actively participate in their own recovery and direct their own care. If the client is unable to designate county of residence, as indicated in OAR 410-200-0200, the Authority shall designate the Home CCO as the geographic location of the client at the most recent residency and CCO enrollment prior to hospitalization.
4. Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:
    a. Upon State Hospital discharge, the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement;
    b. If the client is enrolled in YCCO at the time of the acute care admission to the State Hospital when a bed becomes available, YCCO will be responsible for the covered services during that placement even if the location of the facility is outside the YCCO service area. YCCO responsibility shall be in accordance with a risk sharing agreement to be entered into between YCCO and the State Hospital, in a form required by the Authority. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.
5. For new and existing temporary residential placements, YCCO shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, oral, and transportation when within the scope of YCCO's contract, including when member's temporary placements are outside the YCCO service area. YCCO will coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, YCCO will coordinate all care for accompanying dependent members.
6. Enrollment shall follow the Home CCO enrollment policy outlined in this rule, except when:
    a. The Home CCO enrollment hinders access to care or puts the client at potential harm, or the Home CCO is unable to provide needed unique services, a change in enrollment may be requested for the member to a CCO serving the service area of the temporary out-of-area placement; or
    b. Home CCO enrollment may create a continuity of care concern, (OAR 410-141-3810). If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.
7. If the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO (OAR 410-141-3810). If the individual was enrolled in a different CCO in error, the Authority shall disenroll the individual from the incorrect CCO and recoup the capitation payments (OAR 410-120-1395). Re-enrollment to the correct CCO shall occur (OAR 410-141-3805).
8. For consideration of disenrollment decisions other than specified, OAR 410-141-3810 shall apply. If the Authority determines that disenrollment should occur, YCCO will

continue to provide covered services until the disenrollment date established by the Authority (OAR 410-141-3860). This shall provide for an adequate transition to the next responsible CCO.

Transitions of Care

YCCO ensures members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. 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, and the State Hospital. YCCO coordinates appropriate referrals to ICC services to ensure that the member's rights are met and that there is post-discharge support.

YCCO has systems to assure and monitor transitions in 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 process for members accessing care coordination.

For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), YCCO shall notify the appropriate department office and begin appropriate discharge planning. YCCO shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled with YCCO during the hospitalization preceding the nursing facility placement:

- YCCO shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
- For members who are discharged to Medicare Skilled Care, YCCO shall notify the appropriate department office when YCCO 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;
- YCCO 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.
- YCCO shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs between levels or episodes of care.

See CM Workflow Clinical Support Specialist (CSS) Transition of Care Plan to Plan

Coordinated Care Organization (CCO) and Fee For Service (FFS) Transitions of Care

When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service to YCCO, YCCO 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 YCCO participating provider. YCCO has a process to monitor all transition request between OHP FFS and CCOs.

The transition of care period is the period of time after the effective date of the enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services. The transition of care period last for:

- 90 days for members who are dually eligible for Medicaid and Medicare or
- For other members, the shorter of:
    - 30 days for physical and oral health and sixty days for behavioral health or
    - Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan; or the minimum or authorized prescribed course of treatment has been completed.

The following members, at minimum, will be provided continued access to services when YCCO is the receiving CCO (per OAR 410-141-3850 all receiving CCOs must provide continued access):

- Medically fragile children;
- Breast and cervical cancer treatment program members;
- Members receiving CareAssist assistance due to HIV/AIDS;
- Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services (including pre-transplant and post-transplant services), radiation, or chemotherapy services; and
- Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Members identified above will be provided the following services during the transition of care period by YCCO when YCCO is the receiving CCO (per OAR 410-141-3850 all receiving CCOs must provide these services):

- Continued access to services and the support necessary to access those services such as Non-Emergency Medical Transportation (NEMT);
- Permission to continue receiving services from the member's previous provider, regardless of whether the provider participates in the YCCO network;
- Referrals to appropriate providers of services that are in the network at the duration of the transition of care period;
- Even with permission to continue from the member's previous provider YCCO is responsible for continuing the entire course of treatment with the member's previous provider as described in the following service specific transition of care period situations:
    - Prenatal and postpartum care;
    - Transplant services through the first-year post-transplant;
    - Radiation or chemotherapy services for the current course of treatment; or
    - Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.
- Where OAR 410-141-3850 allows members to continue using their previous provider, YCCO as the receiving CCO will reimburse non-participating providers consistent with OAR 410-120-1295 at no less than Medicaid fee-for -service rates;
- YCCO as the receiving CCO is not financially responsible for a continuous inpatient hospitalization for which a predecessor CCO was responsible under its contract, in accordance with OARs 410-141-3500, 410-141-3710, and 410-141-3805.

After the transition of care period ends, YCCO as the receiving CCO will remain responsible for care coordination and discharge planning activities as described in OAR 410-141-3870.

The predecessor plan shall fully and timely comply with request for historical utilization data and clinical records within 7 calendar days of the request from the receiving CCO.

- YCCO will not delay the provision of services if historical utilization data and clinical records is not available in a timely manner;
- In such instances, YCCO will approve claims for which it has received no historical utilization data and clinical records during the transition of care time period, as if the covered services had preauthorization. YCCO has a process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted in 45 CFR 170.213 the United States Core Data for Interoperability. Such information is incorporated into YCCO records about the current member. With the approval and at the direction of a current or former member or the member's personal representative, YCCO will:
    - Receive all such data for a current member from any other payer that has provided coverage to the member within the preceding 5 years;
    - At any time, the member is currently enrolled in YCCO and up to 5 years after disenrollment, send all such data to any other payer that currently covers the member or a payer the member or the member's personal representative specifically requests receive the data; and
    - Send data received from another payer in the electronic form and format it was

received.

- YCCO as the receiving CCO will follow all service authorization requirements per OAR 410-141-3835 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. YCCO will use the Notice of Action/Adverse Benefit Determination template approved by OHA which has all notice requirements and will follow timeframes per 42 CFR 438.404 and OAR 410-141-3885.

Post Hospital Extended Care Benefit

- The post hospital extended care benefit (OAR 410-120-1210(4)) is an OHP benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.
- The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.
- To be eligible for the post hospital extended care benefit, the individual must meet all of the following:
  1. Be receiving OHP Plus or Standard, Fee-for-Service benefits;
  2. Not be Medicare eligible;
  3. Have a medically necessary, qualifying hospital stay consisting of:
     - A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.
     - The stay must consist of three or more consecutive days, not counting the day of discharge.
  4. Transfer to a nursing facility within 30 days of discharge from the hospital;
  5. Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criterion that may be provided only in a nursing facility meaning:
     - The individual is at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;
     - The individual's condition requires daily transportation to a hospital or rehabilitation facility by ambulance; or
     - It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.
- The individual may qualify for another 20-day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.
- Individuals eligible for the 20-day post-hospital extended care benefit are not eligible for long term care nursing facility or Medicaid home and community-based services unless the individual meets the eligibility criteria in OAR 411-015-0100 or 411-320-0080.

See UM Workflow Prior Authorization

COMPLIANCE & OVERSIGHT:

Oversight

1. YCCO will routinely verify that subcontractors have policies and procedures as well as provide oversight of participating providers regarding care coordination.
2. YCCO will request subcontractor internal case management audits to ensure subcontractors are monitoring files.
3. Referral and care coordination data will be routinely requested by YCCO of all subcontractors for review by appropriate YCCO staff and/or committees.
4. YCCO will routinely verify that subcontractors are reviewing the quality assurance data and responding to findings of those members who require monitoring.
5. Routine care profile and/or care plan audits will take place insuring compliance with assessment and notification standards as appropriate using a CM Care Profile/Care

Plan tool.

Compliance

YCCO will review and update the following:

- YCCO HRA at least annually and use the annual HRA Evaluation Criteria provided by OHA to ensure all required criteria is present. YCCO will fill out and submit the criteria tool with a Word version of the HRA to OHA for approval via the CCO Deliverable Portal. The HRA will not be utilized until approved by OHA.
- YCCO Care Coordination policies and procedures to ensure OHP Health Plan Services contract requirements, Oregon Administrative and Federal rules are present. Policies will be updated as needed and submitted to OHA for approval with the use of a policy evaluation criteria tool if available from OHA and submitted for approval through the OHA CCO Deliverable Portal.

REPORTING:

YCCO shall monitor and document care coordination activities and the effectiveness of those efforts in a Care Coordination Activities report submitted to the Authority as directed in the Oregon Health Plan Health Plan Services Contract.

REFERENCES:

OARs 410-120-1210(4),410-120-1395, 410-200-0200, 410-141-3500, 410-141-3710, 410-141-3800, 410-141-3805, 410-141-3810, 410-141-3835, 410-141-3850, 410-141-3860, 410-141-3870, 410-141-3875 - 410-141-3895
42 CFR 438.404 and 438.62, 45 CFR 170.213
ORS 414.679
Oregon Health Plan Health Plan Services Contract
The Americans with Disabilities Act of 1990
Health Insurance Portability & Accountability Act of 1996
Title VI of the Civil Rights Act of 1964

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
CM-002 Care Coordination Member Needs Identification
CM-001 Care Coordination Administration
QA-007 Subcontractor Oversight
YCCO HRA
YCCO HRA Postcard
YCCO HRA & CM Letters
CM Risk Stratification Workflow
CM Workflow RN Care Manager Post Inpatient Follow Up
CM Workflow Health Services Specialist (HSS) MDT meeting
CM Workflow Clinical Support Specialist (CSS) Transition of Care Plan to Plan
UM Workflow Prior Authorization

LOG OF REVISION

DATE	REVISION	BY WHOM
10/27/2017	Update with additional content and to new format.	JRoe, QA Specialist
11/14/2017	Approved	BRajani MD Medical Director SMcCarthy PhD President/CEO
07/27/2019	YCCO branding updates	JRoe, QA Specialist

08/30/2019	Updated with new delegate HR Screening process and clarification of internal processes.	JRoe, QA Specialist
10/30/2019	Definition Updates, Addition of HR Screening process and guidelines. ENCC/ICC clarifications and updates due to rule changes.	JRoe, QA Specialist
6/29/2020	Updated language to comply with updated OARs; updated OAR references	SEide, Sr. QA & Compliance Mgr
08/01/2020	Definition additions and formatting updates	Jroe, QA Specialist
01/21/2021	OAR updates, formatting, term changes and clarification of information to ensure accuracy.	Jroe, Benefit Administration Supervisor
01/22/2021	Review of all information, formatting and editing to ensure accuracy.	RDoan, RN Health Services Manager
5/19/2021	Included Reporting section with requirements and due dates.	DCarr, LCSW BH & Integration Director; RDoan, RN Health Services Manager
02/27/2021	Updated language to comply with updated OARs and CCO Health Plan Services Contract, updated formatting for clarity.	JRoe, Benefit Administration Supervisor
04/09/2022	Formatting and subcontractor clarification updates only, no content change	JRoe, Benefit Administration Supervisor
12/29/2022	Updates to definitions and reassessment info.	JRoe, Benefit Administration Supervisor
07/15/2024	Updates to policy due to OAR changes and updates for 2024	JRoe, Health Plan Operations Manager
09/06/2024	Procedure updates	SPetrie, Care Management Manager

OHA APPROVAL LOG

DATE	METHOD OF APPROVAL (SharePoint/CCO and MCO Deliverable)
02/12/2020	CCO & MCO Deliverable
11/3/2021	Letter Received from OHA
04/25/2022	Letter Received from OHA

DRAFT