Petition To Amend
An Administrative Rule

Oregon Health Authority
of the State of Oregon

IN THE MATTER OF AMENDMENT	)	
OF OAR 410-141-3160 SEEKING	)	Petition to Amend
CLARIFICATION OF TRANSITION	)	OAR 410-141-3160
PERIOD OF A DCO INTO A CCO.	)	(Integration and Care
	)	Coordination)

I. Petitioners: **R. Mike Shirtcliff, DMD, President/CEO**
Advantage Dental Services, LLC
442 SW Umatilla Ave, Ste 200
Redmond, OR 97756

Tim Freeman, State Representative
900 Court St NE
Salem, OR 97301

Alan Bates, State Senator
900 Court St NE
Salem, OR 97301

II. Other Persons Known To The Petitioners To Be Interested In The Rule:

1. All existing **Dental Care Organizations** including the following:
   a. Access Dental Plan, Inc. – 14201 NE 20th Ave, Ste 2204, Vancouver, WA 98686
   b. Capital Dental Care, Inc.– 3000 Market St. Plaza NE, Ste 228, Salem, OR 97301
   c. CareOregon Dental – 426 SW Stark Street, 9th Floor, Portland, OR 97204
   d. Family Dental Care – 8070 SW Hall Blvd, Ste 200, Beaverton, OR 97008
   e. Managed Dental Care of Oregon, Inc.– 3000 Market St. NE, Ste 222, Salem, OR 97301
   f. ODS Community Health, Inc. – 601 SW 2nd, Portland, OR 97204
   g. Willamette Dental Group, PC – 6950 NE Campus Way, Hillsboro, OR 97124

2. All existing and created **Coordinated Care Organizations** including the following:
   a. AllCare Health Plan – 740 SE 7th Street, Grants Pass, Oregon 97526

b. Cascade Health Alliance, LLC- 2909 Daggett Ave, Ste 200, Klamath Falls, OR 97601
c. Columbia Pacific CCO, LLC – 315 SW Fifth Ave, Portland, OR 97204
d. Eastern Oregon Coordinated Care Organization, LLC – 1211 SW Fifth Ave, Ste 1500-2000, Portland, OR 97204: Attn: Kelly Hagan
e. FamilyCare, Inc. – 825 NE Multnomah, Ste 300, Portland, OR 97232
f. Health Share of Oregon – 315 SW Fifth Ave, Ste 300, Portland, OR 97204
g. Intercommunity Health Network – 3600 NW Samaritan Dr, Corvallis, OR 97330
h. Jackson Care Connect – 315 SW Fifth Ave, Ste 900, Portland, OR 97204
i. PacificSource Community Solutions, Inc. - Central Oregon – P.O. Box 7068, Eugene, OR 97401
j. PacificSource Community Solutions, Inc. Columbia Gorge Region – P.O. Box 7068, Eugene, OR 97401
k. PrimaryHealth of Josephine County, LLC – 315 SW Fifth Ave, Portland, OR 97204
l. Trillium Community Health Plan, Inc. – 1800 Millrace, Eugene, OR 97403
m. Umpqua Health Alliance – 1813 W. Harvard Ave, Ste 206, Roseburg, OR 97471
n. Western Oregon Advanced Health, LLC – 750 Central Ave, Ste 202, Coos Bay, OR 97420
o. Willamette Valley Community Health LLC – 2995 Ryan Drive, SE, Salem, OR 97301

III. Proposed Rule Amendment:

NOTE: (New proposed language is bolded and language to be deleted has a line through it.)

OAR 410-141-3160 - Integration and Care Coordination

(1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must 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 (Plan). CCOs must develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:

(a) CCOs shall ensure the provision of care coordination, treatment engagement, preventive services, community based services, behavioral health services and follow up services for all members with behavioral health conditions;

(b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013 and must notify the Authority within 30 calendar days of executing the contract;

(c) By July 1, 2014, each CCO must have a contractual relationship with any dental care organization that serves members in the area where they reside. **Until July 1, 2017, each Coordinated Care Organization shall provide all Dental Services and Denturist Services under the Oregon Health Plan to a Client solely through a contractual relationship with a Dental Care Organization that existed on or before February 23,**

2012 (the enactment of SB 1580). Prior to July 1, 2017, each Coordinated Care Organization shall not contract directly with any Dentist, Denturist, Dental Hygienist, or a Dental Entity for the purpose of providing Dental Services or Denturist Services to a Client under the Oregon Health Plan. For purposes of this section, "Dental Entity" shall include any dental practice or dental clinic or any other entity that provides dental services whether or not formed as a corporation, limited liability company, partnership or sole proprietor, but shall not include a Dental Care Organization formed on or before February 23, 2012;

(d) CCOs must have adequate, timely and appropriate access to hospital and specialty services. CCOs must establish hospital and specialty service agreements that include the role of patient-centered primary care homes 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;

(e) CCOs must demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care. CCOs shall ensure 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.

(2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:

(a) Demonstrate that 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.

(b) Ensure that members with high health needs, multiple chronic conditions, or behavioral health issues are involved in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(c) Use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the state's 1915(1) State Plan Amendment, and those receiving DHS Medicaid-funded long-term care services. Plans should reflect member family, or caregiver preferences and goals to ensure engagement and satisfaction;

(d) Implement systems to assure and monitor improved 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;

(e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and

facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);

(f) 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;

(g) Communicate its 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.

(3) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:

(a) PCPCHs should become 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) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology, where available;

(c) CCOs must engage other primary care provider (PCP) models to be the primary point of care and care management for members, where there is insufficient PCPCH capacity;

(d) CCOs must develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall ensure that all other services and supports are provided as close to the member's residence as possible.

(4) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO must demonstrate that the other model of patient-centered primary health care shall assure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, 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.

(5) If the member is living in a DHS Medicaid funded long-term care (LTC) nursing facility or community based care facility, or other residential facility, the CCO must communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services:

(a) The CCO shall establish procedures for coordinating member health services, and how it will work 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) CCOs shall coordinate transitions to DHS Medicaid-funded long-term care by communicating with local AAA/APD offices when members are being discharged from an inpatient hospital stay, or transferred between different LTC settings;

(c) CCOs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members' receiving Medicaid-funded LTC services.

(6) For members who are discharged to post hospital extended care, at the time of admission to a skilled nursing facility (SNF) the CCO shall notify the appropriate AAA/APD office and begin appropriate discharge planning. The CCO shall pay for the post hospital extended care benefit if the member was a member of the CCO during the hospitalization preceding the nursing facility placement. The CCO shall notify the SNF and the member no later than two working days before discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the CCO shall notify the appropriate AAA/APD office when the CCO learns of the admission.

(7) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service or PHP 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 a CCO participating provider.

(8) CCOs shall establish agreements 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 mental health services, some of which are not provided under the global budget.

(9) CCOs shall coordinate a member's care even when services or placements are outside the CCO service area. CCO assignment is based on the case member's residence, and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department or health services placements for services including residential placements may be located out of the service area, however, the CCO shall coordinate care while in placement and discharge planning for return to county of origin or jurisdiction. For out of area placements, an out of area exception must be made for the member to retain the CCO enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.

(10) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs such as secure residential facilities, PASSAGES projects, or state hospital, shall receive follow-up services as medically appropriate to ensure discharge within five working days of receipt of notice of discharge readiness.

(11) 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 a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.

(12) CCOs shall accept FFS authorized services, medical, and pharmacy prior authorizations, ongoing services where a FFS prior authorization is not required, and services authorized by the

Division's Medical Management Review Committee for 90 days, or until the CCO can establish a relationship with the member and develop an evidence based, medically appropriate coordinated care plan, whichever is later, except where customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

(13) Except as provided in OAR 410-141-3050, CCOs shall coordinate patient care, including care required by temporary residential placement outside the CCO service area, or out-of-state care in instances where medically necessary specialty care is not available in Oregon:

(a) CCO enrollment shall be maintained in the county of origin with the expectation of the CCO to coordinate care with the out of area placement and local providers;

(b) The CCO shall coordinate the discharge planning when the member returns to the county of origin.

(14) CCOs shall coordinate and authorize care, including instances where 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 the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

IV. Petition Explanation:

A. The Proposed Rule Will Clarify The Transition Period Of DCOs into CCOs.

Petitioners request the Oregon Health Authority ("OHA") amend OAR 410-141-3160 to clarify the requirement in paragraph (1)(c) that: by July 1, 2014, each Coordinated Care Organization ("CCO") shall have a contractual relationship with any Dental Care Organization ("DCO") that serves members in the area where they reside.

In general, OAR 410-141-3160 requires a CCO to develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serves the members in the most integrated setting appropriate to their needs. As part of that requirement, each CCO shall have a contractual relationship with a DCO that serves members in the area where the member resides. OAR 410-141-3160 is unclear as to whether a CCO may form its own dental network to provide oral health. The legislative intent behind giving DCOs a period of time to contract with CCOs in HB 3650 and SB 1580 was to allow a transition period so that DCOs can integrate into a CCO in a manner that does not adversely affect the quality and access to dental care. Paragraph (1)(c) has little to no effective if a CCO has the ability to contract directly with dental providers and circumvent a DCO's ability to transition into a CCO over a period of time. The proposed amendment will allow an orderly transition of oral health into a CCO structure in a manner that will assure continued patient access and continuity of oral health care. One of the Triple Aims is the reduction of health care costs. DCOs have already established an oral health care delivery

model that has, over time, reduced the costs of oral health care. With regard to oral health care, the only way the Triple Aim will be met is to allow DCOs to bring their proven and established delivery model into a CCO through a transition period. The proposed amendment to OAR 410-141-3160 will allow that to happen.

B. Options for Achieving OAR 410-141-3160's Substantive Goals While Reducing Negative Economic Impact on Businesses.

The substantive goal of OAR 410-141-3160 is to provide the CCO Member with integrated person centered care and services to assure that each CCO Member has access to physical, behavioral and oral health so that each Member receives quality health care at the right time, at the right place, and reduces the costs of health care. The proposed language is in line with the substantive goal of OAR 410-141-3160. It will allow all DCOs the opportunity to transition into a CCO in an organized fashion so as to safeguard a Member's access to oral health care and protect the delivery of oral health care all DCOs have created and perfected over the years. It is quite apparent that many CCOs do not fully comprehend the level of complexity a DCO takes on to deliver oral health care in a manner that stays within the DCO's budget.

OHA has proposed an administrative fix to the integration of DCOs into CCOs as outlined in a Memorandum dated August 24, 2012. However, this proposed "fix" could severely cripple the oral health care delivery model established by DCOs which would ultimately result in additional health care costs. Moreover, OHA's proposed administrative "fix" could have the effect of decimating the existing DCOs by substantially decreasing the number of enrollees coming into a DCO.

C. Continued Need for and the Complexity of OAR 410-141-3160.

OAR 410-141-3160 is needed because it sets forth the requirement for integration and care coordination for not only oral health, but also physical health and behavioral health. The new proposed language is added to clarify the transition of a DCO into a CCO.

D. Extent to which OAR 410-141-3160 Overlaps, Duplicates or Conflicts with Other State Rules.

OAR 410-141-3160 is an integral part of health care transformation because it relates to the integration and coordination of health care for physical, behavioral and oral health. OAR 410-141-3160 is referenced in OAR 410-141-3050 and OAR 410-141-3220. Petitioners are not aware of other State rules that overlap, duplicate or conflicts with OAR 410-141-3160.

E. Degree Technology, Economic Conditions, or Other Factors have changed that affect OAR 410-141-3160 since it was adopted.

HB 3650 and SB 1580 both stated that: by July 1, 2014, each Coordinated Care Organization ("CCO") shall have a contractual relationship with any Dental Care Organization ("DCO") that serves members in the area where they reside, for the purpose of allowing a DCO a transition period into a CCO. In recent developments, CCOs have requested an opinion from OHA to determine if a CCO may form their own dental network to provide dental care thus attempting to circumvent the requirement to contract with a DCO. That outcome would negate legislative intent, which was to give DCOs until July 1, 2017 to fully transition into a CCO. (See ORS 414.625 Section 14, subparagraph 4.)

Wherefore, Petitioners request the Oregon Health Authority to adopt the proposed amendment to OAR 410-141-3160.

Dated September 27, 2012.

R. Mike Shirtcliff, DMD, President/CEO
Advantage Dental Services, LLC

Tim Freeman, State Representative

Alan Bates, State Senator

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