

Welcome to Model of Care (MOC) Training

For Providers Seeing
CareOregon Advantage (COA)
Members

MOC Cycle CY2026-2028

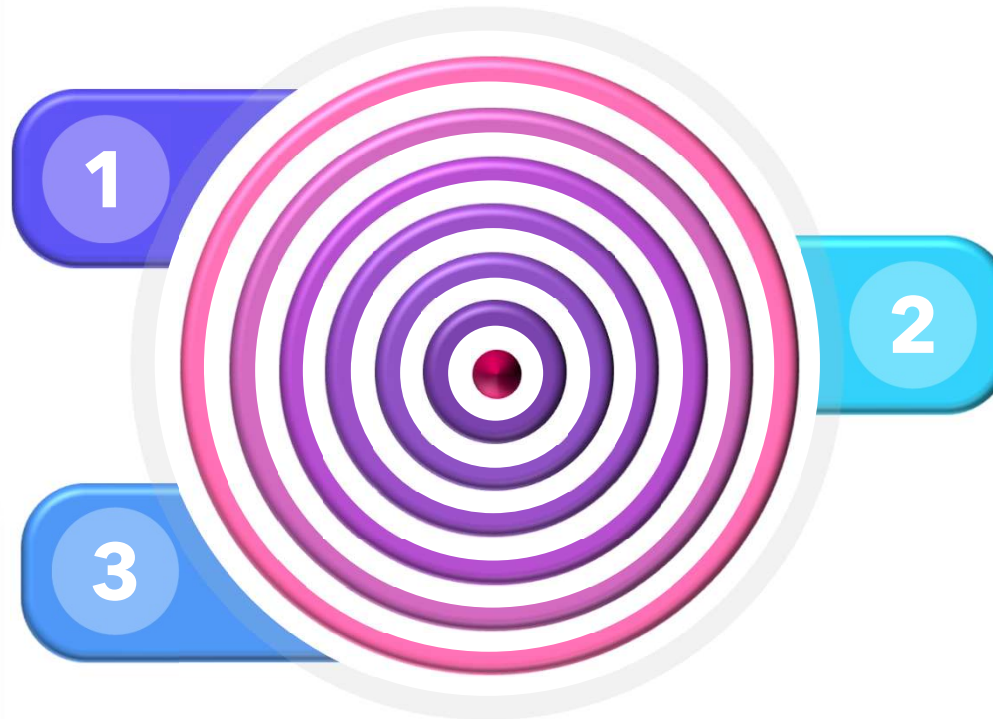


Model of Care (MOC) Provider Training

Learning Objectives

Discover why CareOregon offers this plan and what it hopes to achieve for members.

Get familiar with CareOregon's quality and care coordination goals.



Understand CareOregon Advantage (COA) member demographics and conditions.

Disclaimer

Who is required to take this training?

- All providers who see or treat CareOregon Advantage members.
- “Provider” is defined broadly; each organization can use their own definition.
- CMS Defines the Special Needs Program (SNP) provider network as “a network of health care providers who are contracted to provide health care services to SNP enrollees.”
- CMS regulations at 42 CFR § 422.101(f)(2)(ii) require that SNPs conduct MOC training for appropriate staff (employed, contracted, or non-contracted).



Disclaimer

You are only required to take MOC Training **one time** during the current MOC cycle (between CY2026-2028).

- For example, if you have already taken the training and filled out an attestation form in the calendar year 2026, you do not need to do it again until the next MOC cycle.
- The next MOC cycle begins in CY 2029. CareOregon will reach out to you in 2029 to let you know when the next MOC training is due.

Disclaimer

Other plans' MOC training can be substituted for the COA-specific training.

- You will need to submit a copy of the proposed training materials by attaching it to the [2026 CareOregon Training Attestation](#).
- A CareOregon representative will review the training and reach out to let you know if it is **not** an allowable substitute.

Disclaimer

[Link to Attestation Form](#)

Training is only considered “complete” by CareOregon when **both** of the following requirements are met:

1. The provider has reviewed the training materials
-AND-
2. An individual or organization/facility/clinic attestation is submitted online. Only one attestation is needed per organization, as long as all required staff within the organization have taken the training.

Part 1: Overview of the CareOregon Advantage (COA) Plan

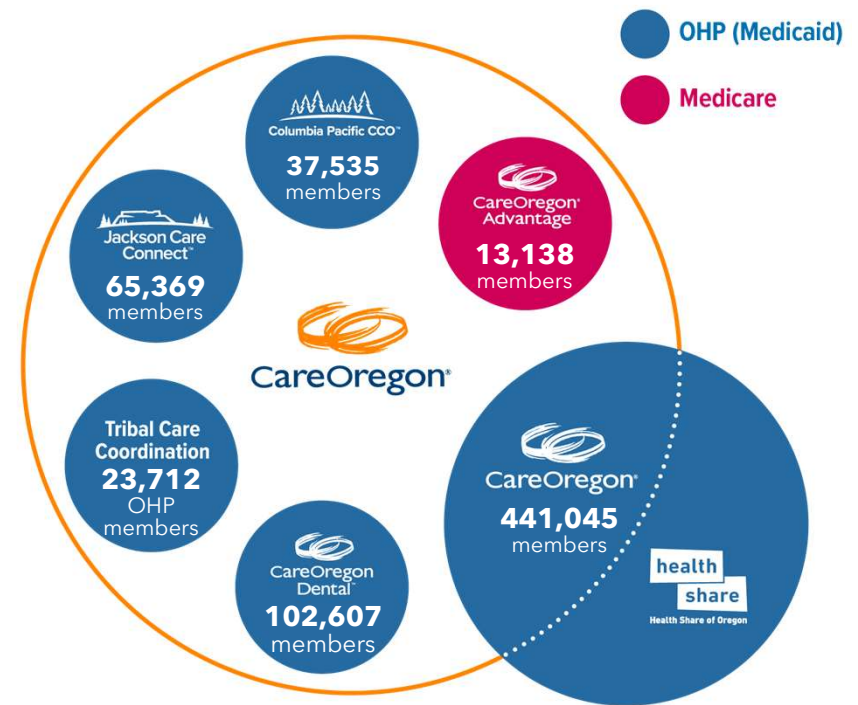


The CareOregon Family

CareOregon is a mission-driven, community based nonprofit organization. For 30 years, CareOregon has offered health services and community benefit programs to Oregon Health Plan members.

Today, we support the needs of over 500,000 Oregonians through three coordinated care organizations, a Medicare Advantage plan, a Tribal Care Coordination program, and a dental care organization.

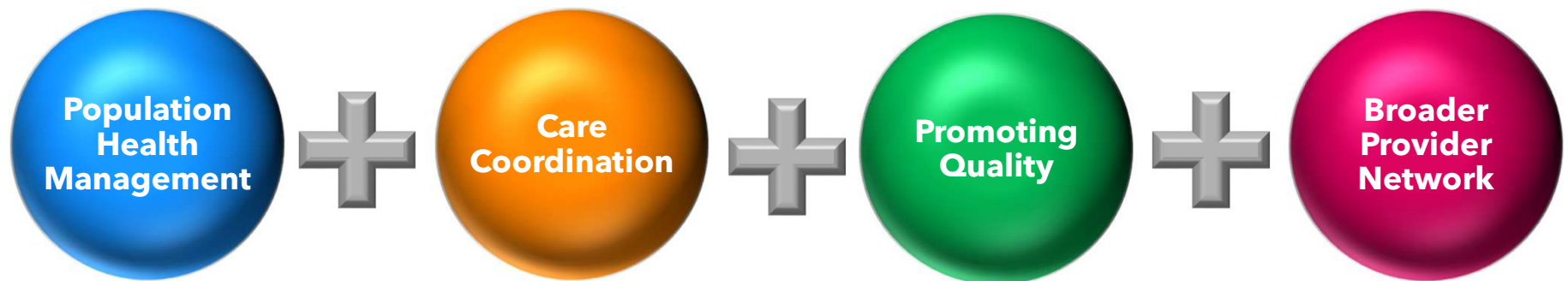
CareOregon members have access to integrated medical, dental and mental health care and substance use treatment. We also connect members to housing, fresh food, education and transportation services.



*** Membership numbers updated as of July 1, 2026

Model of Care (MOC): Both Operating Plan & Written Program

- CareOregon submits its Model of Care plan to the Centers for Medicare & Medicaid Services (CMS) for approval every 1 to 3 years.
- The model is CareOregon's approach to:



Addressing the True Drivers of Health

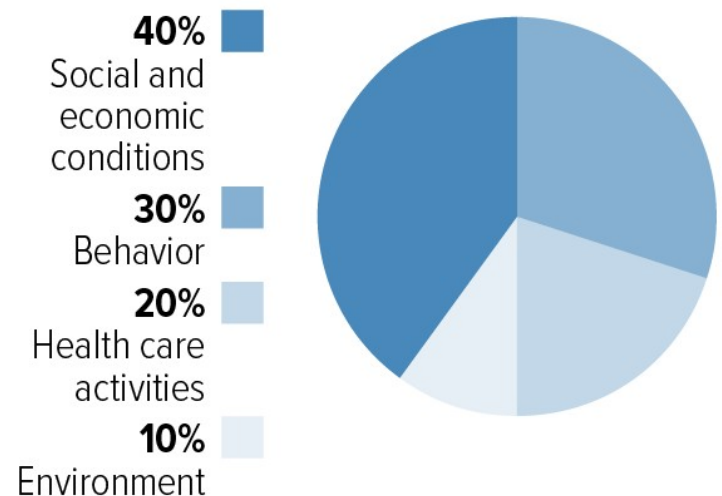
The work of traditional healthcare – providers, hospitals, urgent care, etc. – shapes only 20% of what makes a person healthy.

The rest of the factors – like where you are born, how much money you make, access to clean water and nutritious food, a safe place to play or exercise, smoking or drug use – are very difficult for traditional healthcare to address.

New insurance plan types are needed to cover services which address those missing pieces.

Most Health Outcomes Determined by Factors Other Than Health Care

Factors that shape health



Source: County Health Rankings model, University of Wisconsin Population Health Institute, 2014

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Time for an Acronym Breakdown

CareOregon **Advantage** (COA) Plus HMO-POS D-SNP

- **Medicare Advantage (MA)** plans are private health plans that provide an alternative to Original Medicare for health and drug coverage. MA plans are offered by private companies (like CareOregon, Inc.).
- COA bundles Medicare Part A (hospital insurance), Medicare Part B (medical insurance), and Medicare Part D (prescription drug coverage) into one plan. We have also chosen to offer additional benefits such as vision, hearing, and dental services, plus health and wellness programs.

Time for an Acronym Breakdown

CareOregon Advantage (COA) Plus **HMO-POS** D-SNP

- **Health Maintenance Organization (HMO)** plans create a set network of approved physicians, hospitals, and health care providers to control quality and cost.
- **Point-of-Service (POS)** plans are a type of HMO that allow members to receive certain out-of-network services at a higher cost. POS plans are similar to HMOs but are less restrictive, and members may be able to get care out-of-network under certain circumstances.

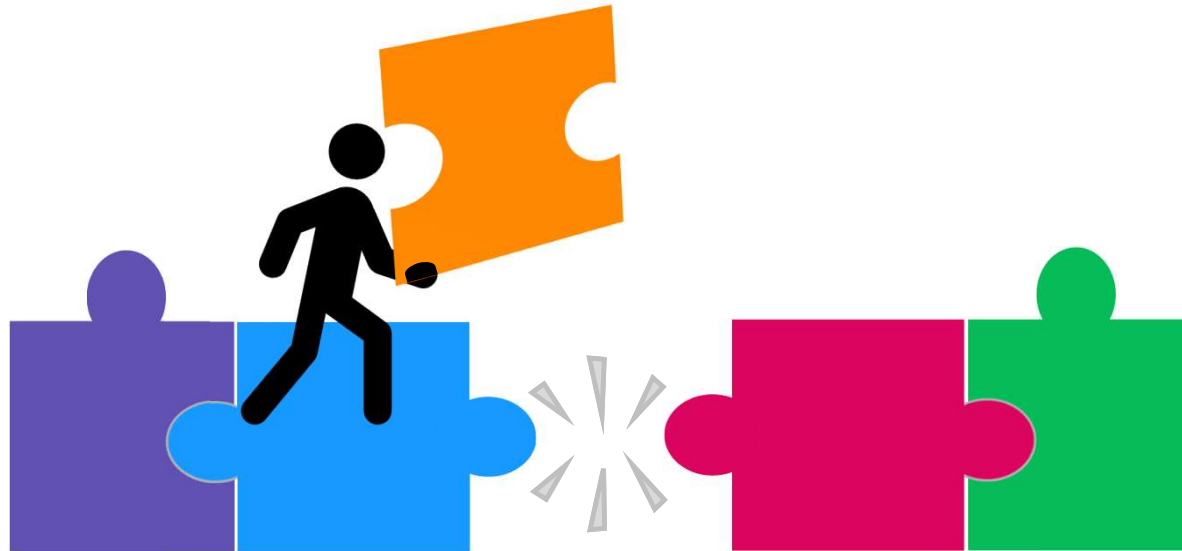
Time for an Acronym Breakdown

CareOregon Advantage (COA) Plus HMO-POS **D-SNP**

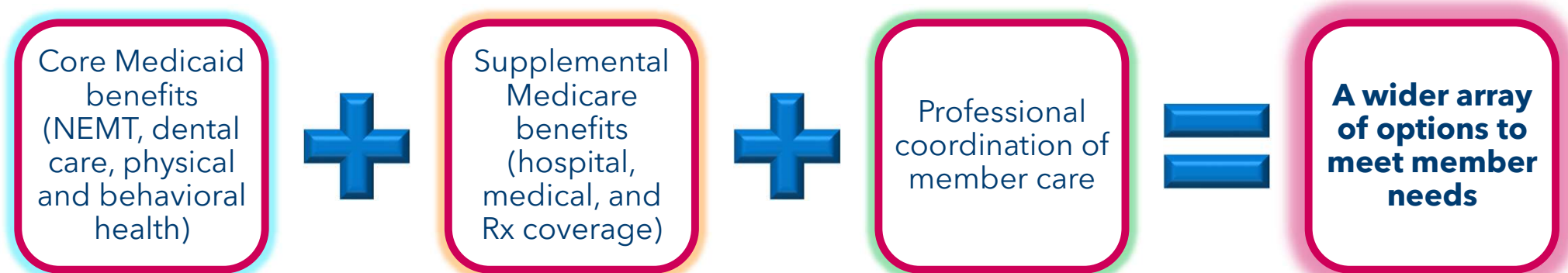
- **Special Needs Plans (SNPs)** are limited to people with specific conditions or diseases. SNPs may offer extra services for specific groups by adjusting benefits, provider options, and drug lists to meet the need.
- There are three different types of SNPs:
 1. Chronic Condition SNP (C-SNP)
 2. **Dual Eligible SNP (D-SNP) - members qualify for both Medicare and Medicaid.**
 3. Institutional SNP (I-SNP)

Why this Matters: D-SNPs in Clinical Practice

- The goals of our Model of Care are to reduce fragmentation for members seeking care, and to produce better health and wellness outcomes.
- CareOregon views the provider as pivotal in driving quality and addressing gaps in care.



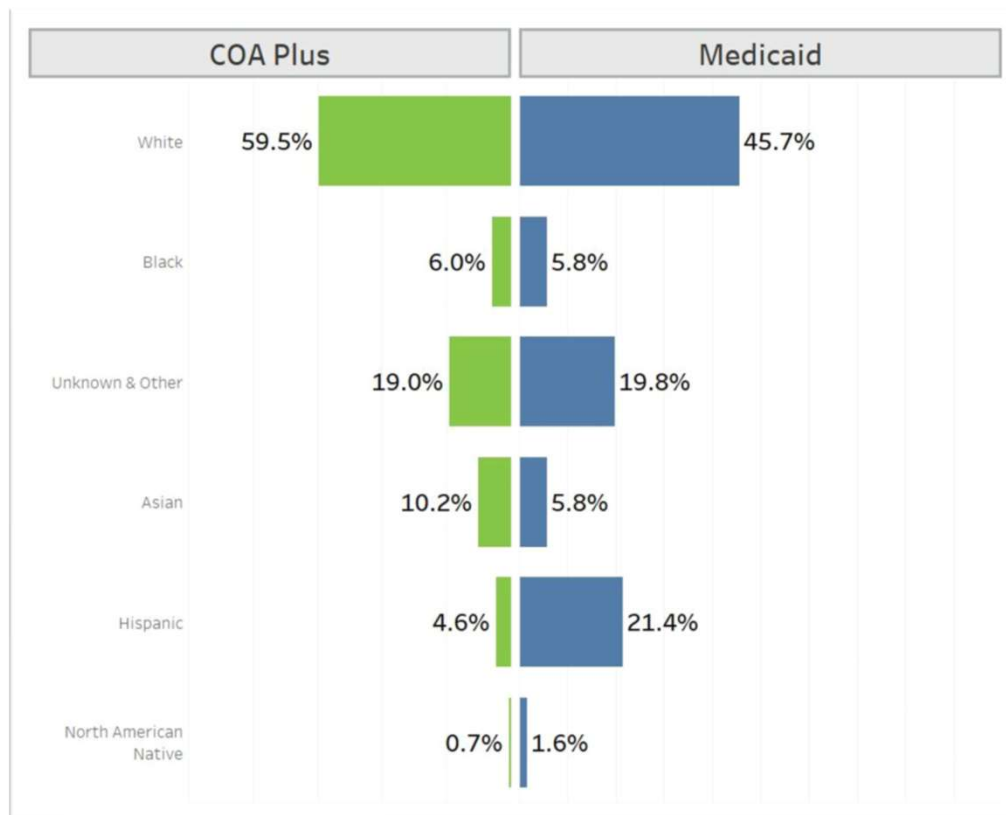
The Importance of Combining Medicaid + Medicare Benefits



Part 2: Plan Member Demographics & Conditions

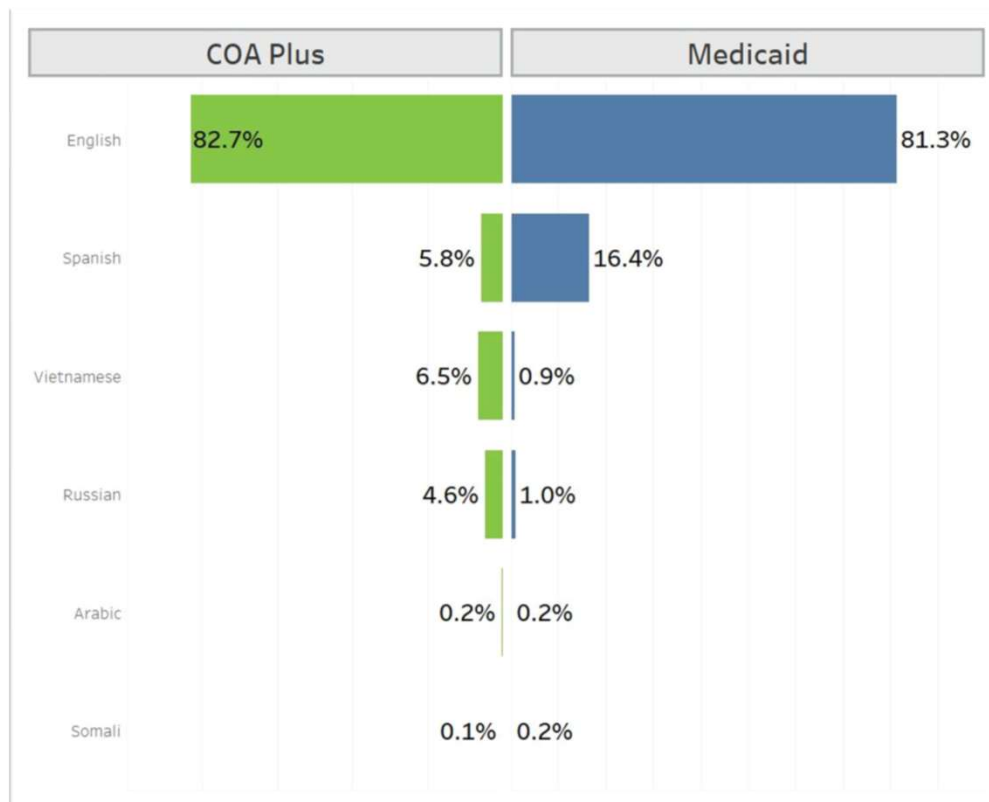


Compare Race/Ethnicity Profile



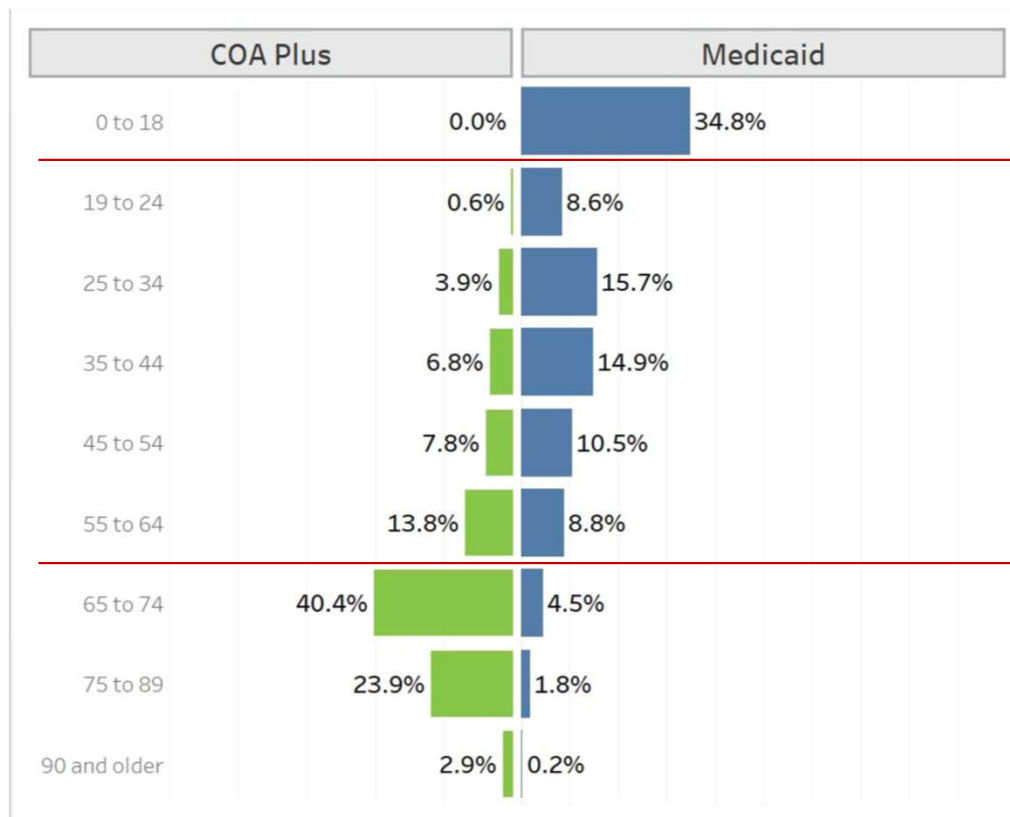
- Medicare has comparatively larger proportions of members who identify as **White** or **Asian**.
- Whereas Medicaid has a higher proportion of members who identify as **Hispanic**.

Compare Spoken Language Preferences

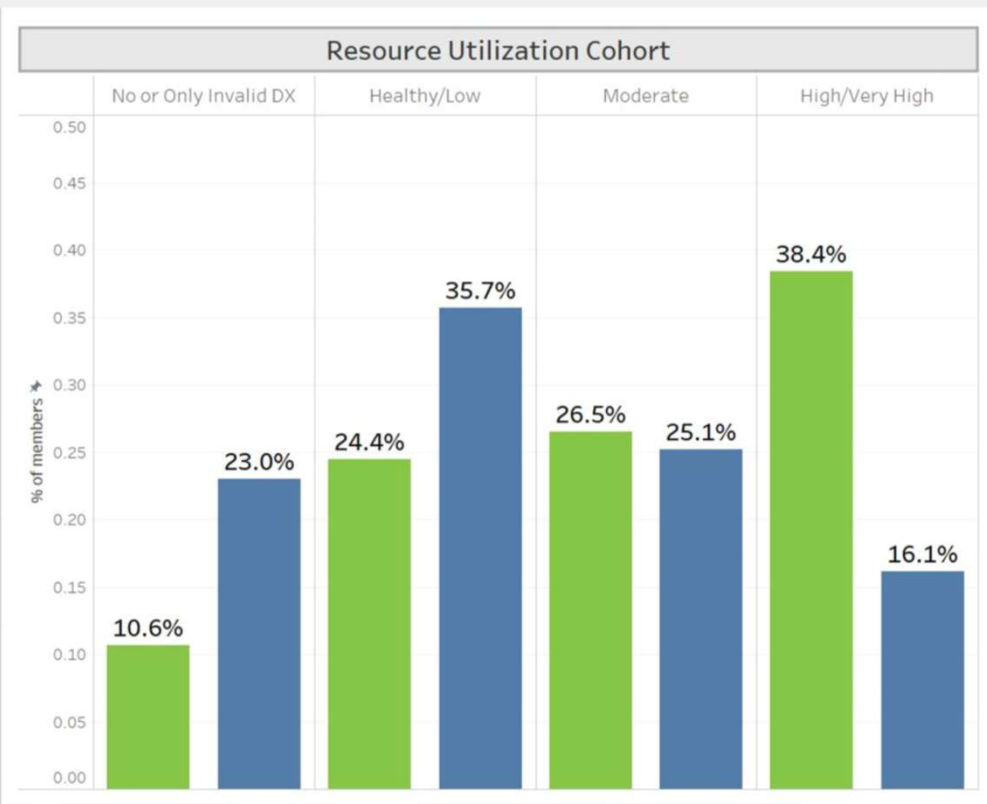


- **Vietnamese** and **Russian** are spoken by a higher proportion of Medicare members, compared to Medicaid members.
- **Spanish** is more commonly spoken by Medicaid members.

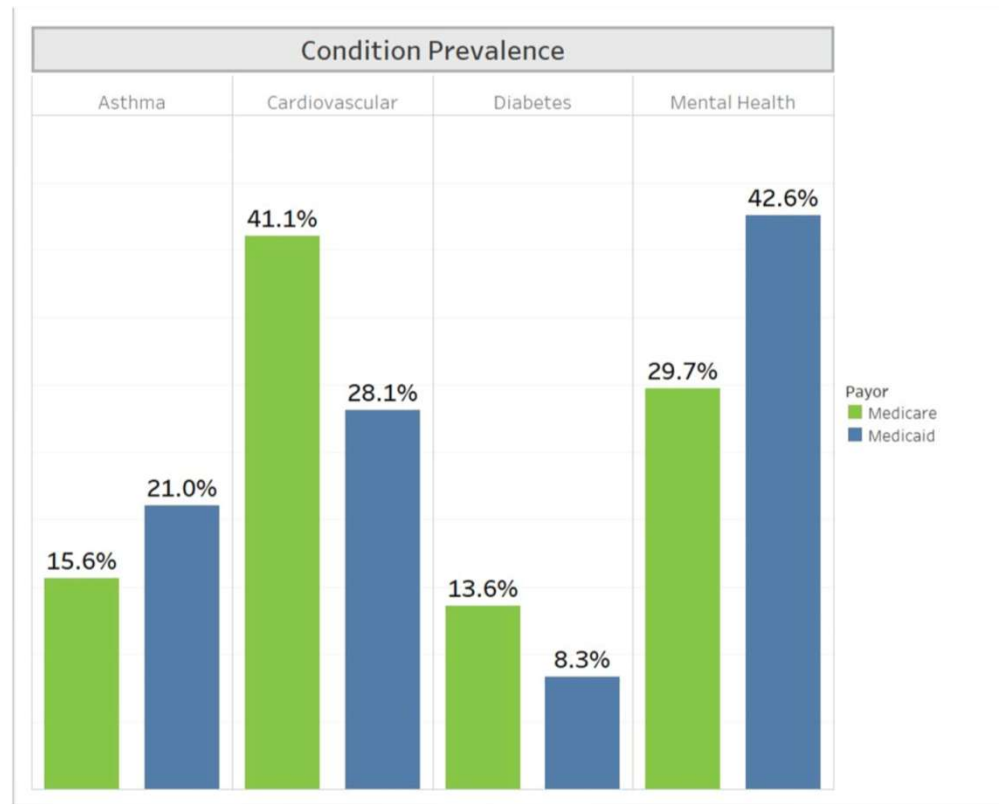
Compare the Age Profile



- **67.2% of Medicare members are age 65 or older, but only 6.5% of Medicaid members are the same ages.** That's because at age 65 a person becomes eligible for Medicare (with certain disability and disease-specific exceptions).
- One out of every 3 Medicaid members is age 18 or younger.



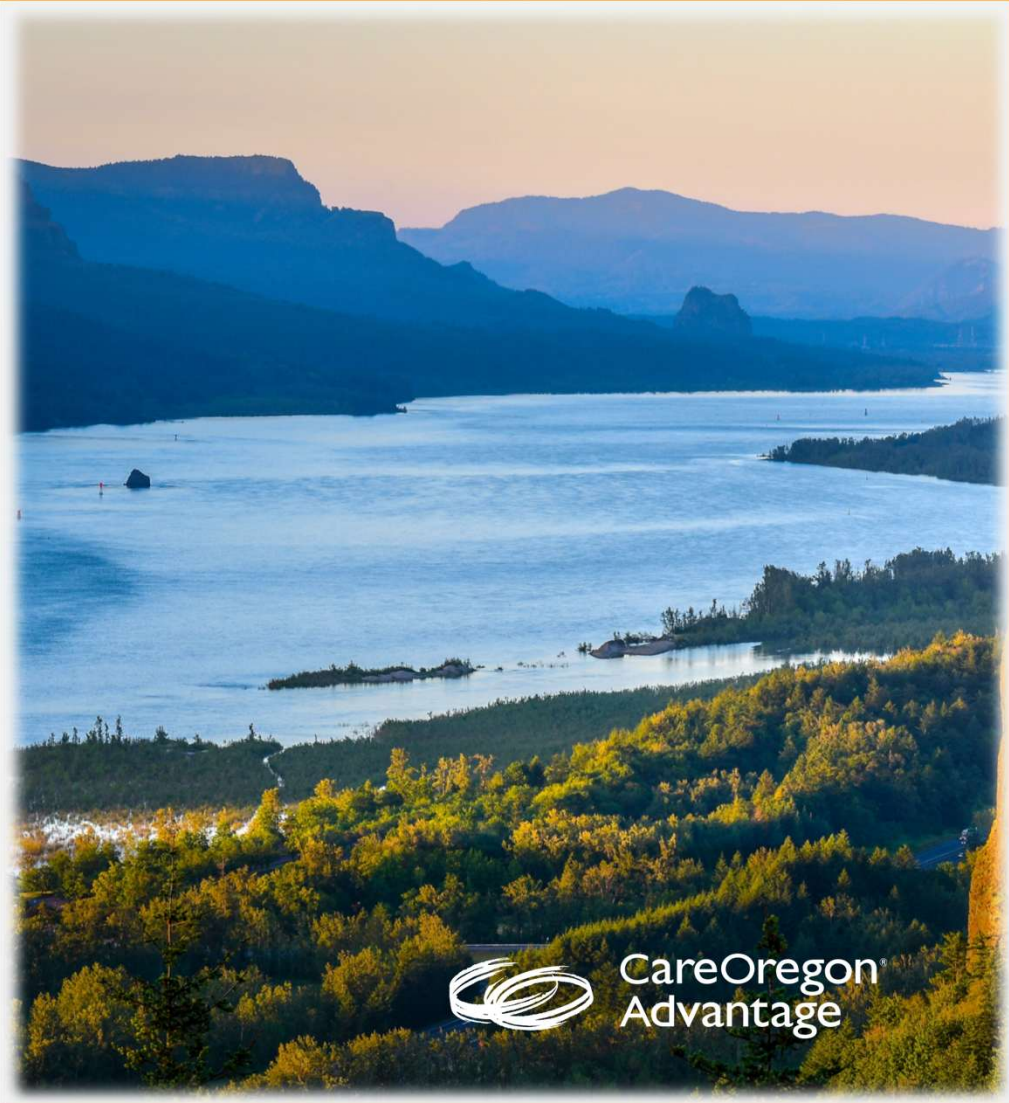
Medicaid members are relatively healthier and use services less often.



Medicare has a higher prevalence of CVD.

Mental health diagnoses are more prevalent in Medicaid members.

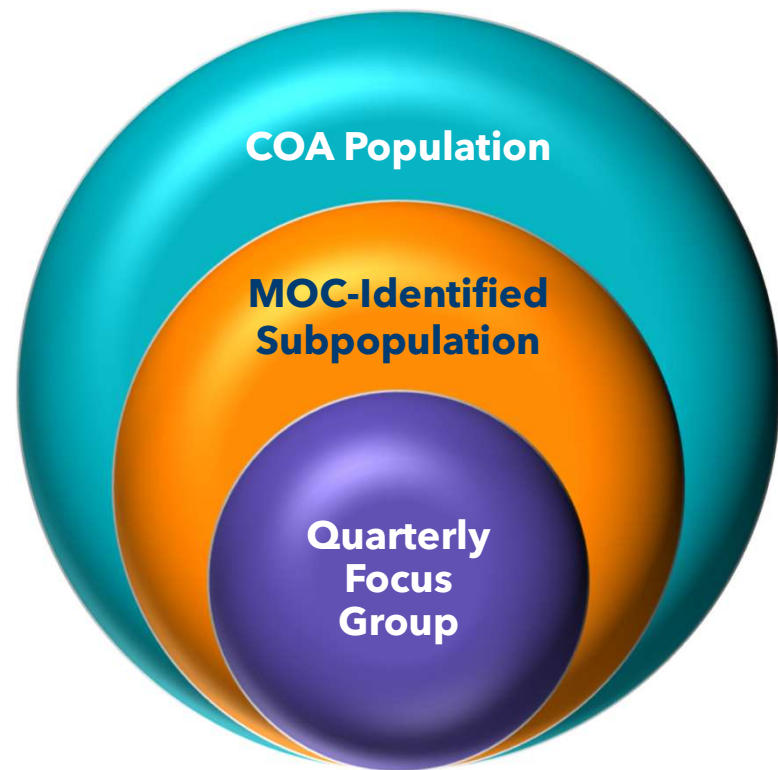
Part 3: Quality & Wellness Focus for Plan Members



Risk-Stratifying Members to Prioritize Intervention

The entire 15,000+ COA membership is stratified according to presentation of clinical, coordination, social, and access risks.

The top ~20% highest risk members are placed into the MOC-Identified Subpopulation, where each quarter ~ 500 of these members are targeted for care coordination outreach.



Priority Population Quality Improvement Efforts Align with Member Population Needs

Chronic Conditions	Mental Health	Substance Use Disorders
• Medication adherence & comprehensive review • Osteoporosis • Diabetes Care • Avoiding readmissions • Follow-up after ED admits • Statin use for DM/Cardio	• Screening for depression • Suicidal ideation readmits • MH + SUD dx retention in treatment programs • Medication adherence • Primary care engagement	• Smoking cessation • SBIRT • IET • Increased naloxone • Increased OUD & AUD medication

How Success is Measured for the COA Model of Care

Clinical Outcomes

- Plan All-Cause Readmissions
- Avoidable ED Visits
- Inpatient & Observation Utilization
- PCP Utilization
- Medication Adherence

Member Satisfaction

- CG-CAHPS
- Net member enrollment/disenrollment

Process Outcomes

- Medicare Stars Rating (SNP Care Management)
- Percent of Total Population Actively Engaged in Care Coordination

Financial Outcomes

- Monthly Risk Score (HCC)
- Total Medical Cost
- Funding PMPM
- Expense PMPM

Part 4: The Role of Care Coordination & Connection with the Provider Network



Different Care Coordinator Disciplines Come Together to Serve COA Members



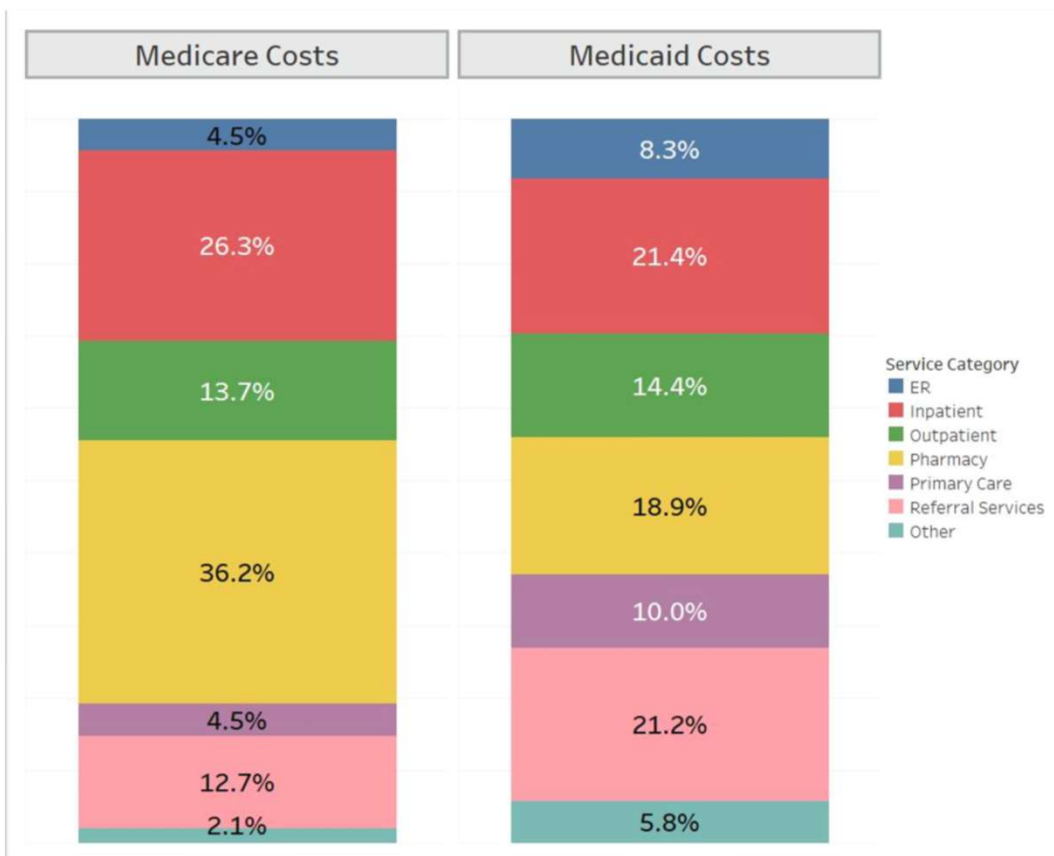
Care Coordinators can add “more tools to the toolbox” of services and supports that are available to our members.

A collaborative, multidisciplinary team creates a single care plan for each member enrolled in care coordination. Members benefit without needing to know how to navigate a complex system.

Members are assigned to a care team located in their home region.

A member’s care plan could be “owned” by CareOregon or by another care coordinator resource available to the member in their network.

What Kinds of Services Do Our Members Use?



Medicare members have a comparatively higher proportion of *Pharmacy* and *Inpatient* costs.

Medicaid members have a higher proportion of costs spent on *Primary Care*, *Emergency*, and *Referral* services.

Four Key Care Coordination Deliverables



All members take a **Health Risk Assessment (HRA)** every year and after major changes in health status.



The **member's care team meets** to triage needs at least once per year, ideally with the member present.



The member's goals and preferences are documented in an **individual care plan (ICP)**.



All members **see any needed provider at least once per year.**

Seeing the Full Picture

Everything comes together to drive performance forward for the benefit of COA members.



Thank you for participating in this training!

***Don't forget to submit your attestation online
to get credit for completion.***

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