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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Semi-Annual CCO Rule Updates

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RULES:
410-141-0060, 410-141-0070, 410-141-3060, 410-141-3070, 410-141-3080, 410-141-3160, 410-141-3170, 410-141-3200, 410-141-3320

REPEAL: 410-141-0060

REPEAL: Temporary 410-141-0060 from DMAP 7-2018

RULE TITLE: Oregon Health Plan Managed Care Enrollment Requirements

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) For the purposes of this rule, the following definitions apply:

(a) “Client” means an individual found eligible to receive health services. “Client” is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) “Eligibility Determination” means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) “Member” means a client enrolled with a pre-paid health plan or coordinated care organization as stated in OAR 410-120-0000;

(d) “Newly Eligible” means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) “Redetermination” means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;
(f) “Renewal” means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.
(2) The following populations may not be enrolled into an MCO or any type of health care coverage including:
(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;
(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;
(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.
(3) The following populations may not be enrolled into an MCO under the following circumstances:
(a) Newly eligible clients are exempt from enrollment with an MCO but not exempt from enrollment in a DCO, if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual will receive dental services through the DCO.
(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in and ORS 414.631 and, except as provided for children in Child Welfare though the BRS and PRTS programs, outlined OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.
(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from auto assignment mandatory enrollment for their managed care plans, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.
(5) Populations specified below are exempt from mandatory enrollment into a physical health MCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member’s service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These individuals are as follows:
(a) Children in the legal custody of the Department or Oregon Health Authority where the child is expected to be in a substitute care placement for less than 30 calendar days unless:
(A) Access to health care on a FFS basis is not available; or
(B) Enrollment would preserve continuity of care.
(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these clients:
(A) A client who is also a Medicare beneficiary and is in a hospice program may not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan unless exempt for some other reason listed in this rule;
(B) The client is enrolled in Medicare and the only FCHP or PCO in the service area is a Medicare Advantage plan. The client may choose not to enroll in an FCHP or PCO;
(C) Enrollment in a FCHP or PCO of a client who is receiving Medicare and who resides in a service area served by PHPs shall be as follows:
(i) If the client who is Medicare Advantage eligible selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the client shall complete the 7208M or other CMS approved Medicare plan election form;
(ii) If the Medicare Advantage Plan Election form (OHP 7208M) described in this rule is signed by someone other than the client, the client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M;
(iii) If the client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative may

not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components:
(I) If the FCHP or PCO has not received the form within ten calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the member with a copy sent to the APD branch manager. The letter shall explain the need for the completion of the form; inform the member that if the form is not received within 30 days, the FCHP or PCO may request disenrollment; and instruct the member to contact their caseworker for other coverage alternatives.
(II) The FCHP or PCO shall choose whether to disenroll or maintain enrollment for all the clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO shall notify the PHP coordinator of the PHP's annual decision to disenroll or maintain enrollment for the clients in writing. This notification shall be submitted by January 31 of each year or another date specified by the Authority. If the FCHP or PCO has decided to:
(III) Disenroll the clients and has not received a client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the member effective the end of the month following the notification;
(D) Maintain enrollment. The FCHP or PCO may not request disenrollment at the end of 30 days.
(E) If the client is enrolled as a private member of a Medicare Advantage plan, the client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:
(F) If the client chooses to remain as a private member in the Medicare Advantage plan, the client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;
(G) If the client chooses to discontinue the Medicare Advantage enrollment and then, within 60 calendar days of disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other clients;
(H) A Fully Dual Eligible (FDE) client who has been exempted from enrollment in an MHO may not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a provider who is on the FCHP's or PCO's panel.
(6) The Authority may temporarily exempt clients from mandatory enrollment for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in MCOs on a case-by-case basis; children not enrolled in a MCO shall continue to receive services on a FFS basis;
(b) Women who are pregnant and meet the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage will continue to be enrolled in the appropriate MCO or CCO plan in their service area for dental and mental health coverage. After the 60 day period, the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in paragraphs A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there shall be no home birth option available to the client through her plan and the client shall:
(A) Be pregnant;
(B) State that her intention is to have a home birth;
(C) Have an established relationship for the purpose of home birth with a licensed qualified practitioner who is not a participating provider with the client’s MCO;
(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and
(E) Meet any OAR and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1), Table 1, either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn, and the client will be subject to MCO enrollment requirements as stated in OAR 410-141-3060;
(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:
(I) Fetal presentation other than vertex when known;
(II) Abnormal bleeding;
(III) Low–lying placenta within 2 cm. or less of cervical os;
(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and
(V) Current substance abuse that has the potential to adversely affect labor and the infant.
(c) The following apply to clients and exemptions relating to organ transplants:
(A) Newly eligible clients are exempt from enrollment with an MCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;
(B) Newly eligible clients with existing transplants shall enroll into the appropriate MCO for their service area;
(d) Other just causes to preserve continuity of care include the following considerations:
(A) Enrollment would pose a serious health risk; and
(B) The Authority finds no reasonable alternatives.
(7) Unless exempted above, enrollment is mandatory in all areas served by an MCO.
(8) When a service area changes from mandatory to voluntary, the member will remain with their PHP for the remainder of their eligibility period unless the member meets the criteria stated in this rule or as provided by OAR 410-141-0080.
(9) If the client resides in a mandatory service area and fails to select a DCO, MHO, PCO, or FCHP at the time of application for the OHP, the Authority shall enroll the client with a DCO, MHO, PCO, or FCHP as follows:
(a) The client shall be assigned to and enrolled with a DCO, MHO, PCO, or FCHP that meets the following requirements where MCO enrollment is not available or services are not available through the MCO:
(A) Is open for enrollment;
(B) Serves the county in which the client resides;
(C) Has practitioners located within the community-standard distance for average travel time for the client.
(b) Assignment shall be made first to an MCO;
(c) The Authority shall send a notice to the client informing the client of the assignments and the right to change assignments within 30 calendar days of enrollment. A change in assignment shall be honored if there is another DCO, MHO, PCO, or FCHP open for enrollment in the county in which the client resides;
(10) Clients shall be enrolled with PHPs according to the following criteria:
(a) Areas with sufficient physical health service capacity through a combination of Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHP), and Physician Care Organizations (PCO) shall be called mandatory service areas. In mandatory service areas, a client shall select:
(A) A CCO; or
(B) An FCHP or PCO:
(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and
(ii) If approved by the Authority.
(b) Service areas without sufficient physical health service capacity shall be called voluntary service areas. In voluntary service areas, a client has the option to:
(A) Select a CCO; or
(B) Select an FCHP or PCO;
(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and
(ii) If approved by the Authority; or
(C) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.

(c) Service areas with sufficient mental health and dental care service capacity through MHOs and DCOs shall be called mandatory MHO and DCO service areas. A client shall select an MHO and DCO in a mandatory MHO and DCO service area if mental health and dental services are not available through a CCO or the client is otherwise exempt from CCO enrollment;
(d) Service areas without sufficient dental care service capacity through MHOs and DCOs shall be called voluntary MHO and DCO service areas. In voluntary MHO and DCO service areas, a client may choose to:
(A) Select a CCO open to enrollment that offers dental services; or
(B) Select any MHO and DCO open for enrollment if CCO enrollment is not available; or
(C) Remain in the Medicaid FFS mental health and dental care delivery system;
(11) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the client and notifies the client of enrollment and the name of the PHP: If enrollment is initiated by an Authority worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by an Authority worker after Wednesday, the date of enrollment shall be one week from the following Monday. Monthly enrollment in a mandatory service area, where there is only one plan or DCO, shall be initiated by an auto-enrollment program of the Authority, effective the first of the month following the month-end cutoff. Monthly enrollment in service areas, where there is a choice of PHPs, shall be auto-enrolled by computer algorithm.
(12) The provision of capitated services to a member enrolled with a PHP shall begin as of the effective date of enrollment with the MCO except for:
(a) A newborn whose mother was enrolled at the time of birth. The date of enrollment shall be the newborn's date of birth;
(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;
(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414, 615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610, 414.685

REPEAL: 410-141-0070

RULE TITLE: Managed Care Fully Capitated Health Plan and Physician Care Organization Pharmaceutical Drug List Requirements

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. Fully Capitated Health Plan (FCHP)'s and Physician Care Organization (PCO)'s shall pay for prescription drugs, except:

(a) As otherwise provided, mental health drugs that are in Class 7 & 11 (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal and those drugs that the Division of Medical Assistance Programs (Division) specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is Fully Dual Eligible.

(2) FCHPs and PCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) FCHPs and PCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but is not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 72-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, FCHPs and PCOs must provide (within 24 hours of receipt of the drug prior authorization request) for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.

(5) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referring provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the Division member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs which have reached the FDA Notice of Opportunity for Hearing NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. The DESI LTE drug list is available at:

https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/data/index.html.
(8) An FCHP or PCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Division no later than March 1 of any given contract year that contains all of the following information:
(a) The name of the drug;
(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and
(c) The reason that the Division should consider this drug for carve out.
(9) Upon receipt of a request from an FCHP or PCO requesting a drug not be paid within the capitation rate of the FCHP or PCO, the Division shall exclude the drug from capitation rate for the following January contract cycle if the Division determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar or schizophrenic disorders.
(10) The Division shall pay for a drug that is not included in the capitation rate pursuant to the Pharmaceutical Services rules (chapter 410, division 121). An FCHP or PCO may not reimburse providers for carved out drugs.
(11) FCHPs and PCOs shall submit quarterly utilization data, within 60 days of the date of service, as part of the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: 414.065

AMEND: 410-141-3060

RULE TITLE: Enrollment Requirements in a CCO

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) For the purposes of this rule, the following definitions apply:

(a) “Client” means an individual found eligible to receive OHP health services;

(b) “Eligibility Determination” means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) “Member” means a client enrolled with a pre-paid health plan or a coordinated care organization as stated in OAR 410-120-0000;

(d) “Newly Eligible” means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) “Renewal” as stated in OAR 410-200-0015 means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) Pursuant to ORS 414.631, the following populations may not be enrolled into a CCO for any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals, and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into a CCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with a CCO but not exempt from enrollment in a DCO if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual shall receive dental services through the DCO;

(b) The client is covered under a major medical insurance policy or other third-party resource (TPR) that covers the cost of services to be provided by a PHP as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt mandatory enrollment into a managed care plan, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health CCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member’s service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These populations are as follows:

(a) Children in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days unless:
(A) Access to health care on a FFS basis is not available; or
(B) Enrollment would preserve continuity of care.
(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these:
(A) A client has the option to enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;
(B) A client enrolled in Medicare Advantage, whether or not they pay their own premium, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;
(C) A client has the option to enroll with a CCO even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;
(D) A client has the option to enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.
(6) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;
(b) Separate from requirements in 410-141-3080(3)(c)(A), a pregnant woman at any point prior to the end of the twenty-seventh week and sixth day of pregnancy who meets the qualifications in sub-sections A through D below may receive OHP benefits on a FFS basis for physical health only, until 60 days post estimated date of delivery. Women receiving services on a FFS basis for their physical health plan coverage shall continue to be enrolled in the appropriate CCO plan in their service area for dental and mental health coverage. Sixty days after the estimated date of delivery, the member shall re-enroll in a CCO plan as appropriate. Qualifying criteria are as follows:
(A) Be pregnant;
(B) Have an established relationship for the purpose of out-of-hospital birth with a licensed practitioner who is not a participating provider with the client's CCO;
(C) Make a request to change to FFS. This request can be made through the end of the twenty-seventh week and sixth day of pregnancy;
(D) Meet OAR requirements including the HERC Prioritized List Guideline Note: #153 "Planned Out-of-Hospital Birth" coverage criteria by reference of OAR 410-141-0520 and statutory requirements that define when an out-of-hospital birth is eligible for reimbursement by the Authority;
(c) If a woman becomes unable to meet the requirements in A through D above, the exemption shall be withdrawn and the client shall be subject to CCO enrollment requirements as stated in OAR 410-141-3060.
(d) The following apply to clients and exemptions relating to organ transplants:
(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;
(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area.
(e) Other just causes to preserve continuity of care include the following considerations:
(A) Enrollment would pose a serious health risk; and
(B) The Authority finds no reasonable alternatives.
(7) Unless stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.
(8) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP.
(9) Enrollment is mandatory in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. If upon application or redetermination a client does not select a CCO, the Authority

shall auto-assign the client and the client's household to a CCO that has adequate health care access and capacity. The following outlines the priority of enrollment in service areas where enrollment is mandatory and a PHP remains available for enrollment:
(a) Priority 1: The client shall enroll in a CCO that serves that area and has adequate health care access and capacity;
(b) Priority 2: The client has the option to enroll in a PHP through a manual process if:
(A) The client has an established relationship with a provider who is only contracted with the PHP; or
(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members. Clients shall be FFS unless already established with a PHP's provider.
(c) Priority 3: The client shall receive services on an FFS basis.
(10) If a service area changes from mandatory enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-141-3080.
(11) Clients who are exempt from physical health services or who are enrolled with a PHP for physical health services shall receive managed or coordinated mental health and oral health services as follows:
(a) The client shall be enrolled with a CCO if the CCO offers mental health and oral health services; or
(b) The client shall be enrolled with an MHO for mental health services and with a DCO for oral health services if the CCO does not offer those services; or
(c) The client shall be enrolled with a DCO for oral health services and remain FFS for mental health services if an MHO is not available; or
(d) The client shall remain FFS for both mental health and oral health services if an MHO or DCO is unavailable.
(12) The following pertains to the effective date of the enrollment. If the enrollment occurs:
(a) On or before Wednesday, the date of enrollment shall be the following Monday; or
(b) After Wednesday, the date of enrollment shall be one week from the following Monday.
(13) Coordinated care services shall begin as of the effective date of enrollment with the CCO except:
(a) In the case of a newborn whether the mother is enrolled in any level of CCO or FFS on the date of birth. In these instances, the effective date of coverage for the newborn would be the date of birth.:
(A) If the mother is enrolled in a CCO, the newborn shall be enrolled in the same CCO;
(B) If the mother is in FFS for medical, dental, and mental health, the newborn shall be FFS and shall be auto assigned after eligibility begins at date of birth.
(b) For persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;
(c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;
(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3070

RULE TITLE: Preferred Drug List Requirements

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. MCEs shall pay for prescription drugs except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants) (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (13), (14), and (15) of this rule;

(c) For drugs covered under Medicare Part D when the client is fully dual eligible.

(2) MCEs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.

(3) MCEs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through prior authorization (PA).

(4) MCEs shall publish up-to-date, accurate, and complete lists of all covered drugs on their preferred drug lists, including any tiering structures, that have been adopted and any restrictions on the manner in which certain drugs may be obtained.

(5) As specified in 45 CFR 156.122, the preferred drug list must:

(a) Exist in a manner easily accessible to members and potential members, state and federal government, and the general public;

(b) Be accessible on the plan's public website in a machine-readable format through a clearly identifiable web link or tab without requiring an individual access account or policy number;

(c) Be made available in paper form if requested by a member; and

(d) If the issuer has more than one plan, the member shall be easily able to discern which of the preferred drug lists applies to which plan.

(6) The preferred drug list shall:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(7) MCEs shall cover at least one form of contraception within each of the eighteen methods identified by the FDA. As set forth in OAR 410-141-3320, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating provider.

(8) MCEs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include but are not limited to:

(A) Addition of a new drug;
(B) Removal of a previously listed drug; and
(C) Generic substitution.
(9) Prior authorization for prescription drug requests shall be addressed by the MCEs in the following manner:
(a) Responding to prior authorizations for prescription drugs within 24 hours as described in CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. A response may include:
(A) A request for additional documentation when the prior authorization request lacks sufficient information or documentation to render a decision;
(B) If the necessary additional documentation is not received within 72 hours of the response, the prior authorization may be denied;
(C) The MCE shall make a decision within 24 hours of receiving the necessary information if additional information or documentation is received;
(D) If a substantiated medical emergency justifies the immediate medical need for the drug during this review process, an emergency 72-hour supply shall be made available until the MCE makes a final coverage decision.
(b) Requests shall be addressed by the MCEs by:
(A) Responding to the requestor by telephone or other telecommunication device within 24 hours of a request for prior authorization; and
(B) Contacting the provider within two working days of receipt of the request. The MCE shall notify providers in writing of an approval or a denial, as outlined in OAR 410-141-3240.
(10) MCEs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the prescriber certifies medical necessity for the drug such as:
(a) The equivalent of the drug listed has been ineffective in treatment; or
(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.
(11) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.
(12) MCEs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the list available at:
https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e
(13) An MCE may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all the following information:
(a) The drug name;
(b) The FDA approved indications that identify the drug may be used to treat a severe mental health condition; and
(c) The reason the Authority should consider this drug for carve out.
(14) If an MCE requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.
(15) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). An MCE may not reimburse providers for carved-out drugs.
(16) MCEs shall submit quarterly utilization data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.
(17) MCEs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. MCEs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

(18) MCEs shall utilize a pharmacy and therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, as long as all committee requirements for both committee types are met. A P&T committee must maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR 156.122(3)(i) and (ii). Meetings shall be held at least quarterly. MCEs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations.
(19) The committee in its DUR capacity shall assure prescriptions are appropriate, medically appropriate, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined by 42 CFR 456, subpart K.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610–414.685

AMEND: 410-141-3080

RULE TITLE: Disenrollment from Coordinated Care Organizations

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. Continuity of care is a concern when a member is transferred from one service provider to another.
(2) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.
(3) In accordance with 42 CFR 438.56(c)(2), the Authority or CCO shall honor a member or representative request for disenrollment for the following:
(a) Without cause (applies to MAGI and non-Medicare APD members as defined by the Office of Client and Community Services Medical Programs OAR 410-200-et al):
(A) Members may request to change their CCO enrollment within 30 days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle;
(B) Members may request to change their CCO enrollment within 90 days of the initial CCO enrollment. If approved, the change would occur during the next weekly enrollment cycle;
(C) Members may request to change their CCO enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month;
(D) Members may request to change their CCO enrollment during OHP eligibility renewal, as defined in OAR 410-141-3060. The OHP eligibility period is typically 12 months. If approved, the change would occur at the end of the month;
(E) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. The plan change shall be considered "recipient choice." If approved, the change would occur at the end of the month. Once the recipient choice option has been applied, the member must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.
(b) With cause:
(A) At any time;
(B) Due to moral or religious objections, the CCO does not cover the service the member seeks;
(C) When the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include but are not limited to:
(i) The member moves out of the CCO service area;
(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care

services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;
(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060, or as defined in this rule. Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP member or a provider of a treatment, service, or supply, including but not limited to a decision of a provider to participate or decline to participate in a CCO;
(iv) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one CCO to another CCO if:
(I) The member's provider has contracted with the receiving CCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO; and
(II) Members are offered the choice of remaining enrolled in the transferring CCO; and
(III) The member and all family (case) members shall be transferred to the provider's new CCO; and
(IV) The transfer shall take effect when the provider's contract with their current CCO contractual relationship ends, or on a date approved by the Division; and
(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO and determined that the CCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and
(VI) The Division shall provide notice of a transfer to members affected by the transfer at least 90 days before the scheduled date of the transfer.
(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-3230 and 410-141-3235 of their right to file a grievance or request a hearing.
(c) If the following conditions are met:
(A) As supported in 42 CFR 438.56(d)(2), if a member is at any point in the third trimester of pregnancy and if the member is newly determined eligible for OHP, or the member is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or
(B) If the member is enrolled with a new CCO that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider;
(C) The enrollment exemption shall remain in place until 60 days postdate of delivery of the member's child, at which time the member shall select and be enrolled in the appropriate CCO plan in their service area.
(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:
(A) Transfer of a member from a PHP to a CCO;
(B) Involuntary transfer of a member from a CCO to another CCO; or
(C) Automatic enrollment of a member in a CCO.
(e) Member disenrollment requests are subject to the following requirements:
(A) The member shall join another CCO unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060 or 410-141-0060, or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another CCO in the service area;
(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;
(C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.
(4) The CCO may not disenroll members solely for the following reasons:
(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;
(c) Because of the member's utilization of services, either excessive or lack thereof;
(d) Because the member requests a hearing;
(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO disagrees;
(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.
(5) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO requests it for cause, which includes but is not limited to the following:
(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or http://www.oregon.gov/DHS/abuse/pages/fraud-reporting.aspx as appropriate, consistent with 42 CFR 455.13;
(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060;
(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:
(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;
(B) There shall be notification from the provider to the CCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO. Such notification shall be documented in the member's clinical record. The CCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;
(C) The CCO shall contact the member either verbally or in writing, if it is a severe problem, to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO shall inform the member that their continued behavior may result in disenrollment from the CCO;
(D) The CCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;
(E) The CCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;
(F) If the severity of the problem warrants, the CCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;
(G) The CCO shall submit any additional information or assessments requested by the Division CAR;
(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;
(I) If the member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence as the result of his or her special needs or disability, the CCO shall also document each of the following:
(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO shall

make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;
(ii) A CCO-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;
(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;
(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;
(v) Documentation of the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members;
(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO shall attempt to locate another PCP on their panel who shall accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO's policies and shall be consistent with CCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.
(d) In addition to the requirements in subsection (c), requests by the CCO for an exception to the routine disenrollment process shall include the following:
(A) In accordance with 42 CFR 438.56, the CCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO's staff so that it seriously impairs the CCO's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member may cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;
(B) Providers shall immediately notify the CCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;
(C) The CCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;
(D) The CCO shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;
(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO shall also document each of the following:
(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (5)(c)(I)(i) of this rule;
(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.
(F) Documentation shall exist that verifies the provider or CCO immediately reported the incident to law enforcement.

The CCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;
(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others;
(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;
(I) Documentation shall exist that verifies the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members.
(e) Approval or denial of disenrollment requests shall include the following:
(A) If there is sufficient documentation, the request shall be evaluated by the CCO's CAR or a team of CARs who may request additional information from Ombudsman Services, the Division, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;
(B) In cases where the member is also enrolled in the CCO's Medicare Advantage plan, the CCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;
(C) If there is insufficient documentation, the CAR shall notify the CCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;
(D) The CARs shall review the request and notify the CCO of the decision within ten working days of receipt of sufficient documentation from the CCO;
(E) Written decisions shall be sent to the CCO within 15 working days from receipt of request and sufficient documentation from the CAR.
(6) The following procedures apply to all denied disenrollment requests:
(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO and the member's care team;
(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint, as specified in 410-141-3230 through 410-141-3248, and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;
(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;
(d) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO again requests disenrollment for cause, the request shall be referred to the Authority assessment team for review.
(7) The following procedures apply to all approved disenrollment requests:
(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO and the member's care team;
(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint as specified in OAR 410-141-3230 through 410-141-3248 and to request an administrative hearing and the option to continue enrollment in the CCO pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;
(c) The disenrollment effective date shall be ten calendar days after the disenrollment notice is sent to the member,

unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an administrative law judge's decision to uphold disenrollment;
(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;
(e) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.
(8) Other reasons for the CCO's requests for disenrollment may include the following:
(a) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization and the 20-day post-hospital extended care (PHEC) benefit when appropriate. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;
(b) The member has surgery scheduled at the time their enrollment is effective with the CCO, the provider is not on the CCO's provider panel, and the member wishes to have the services performed by that provider;
(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO;
(d) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Health Insurance Group (HIG) at www.reporttpl.org and HIG send the CCO an email receipt, including a tracking number. The CCO may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO A or B, effective the end of the month the TPL is reported, as referenced above, and the member is not reflected on that month's 834 report;
(e) If a CCO has knowledge of a member's change of address, the CCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO if the member no longer resides in the CCO's service area. Members shall be disenrolled if out of the CCO's service area for more than three months unless previously arranged with the CCO or DCO. The effective date of disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO;
(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from CCO's for members who have been taken into custody;
(g) The member is in a state psychiatric institution.
(9) The Division may initiate and disenroll members as follows:
(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;
(b) If the member moves out of the CCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO;
(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;
(d) If the member dies, the last date of enrollment shall be the date of death.
(10) Unless specified otherwise in these rules or in the Division notification of disenrollment to the CCO, all

disenrollments are effective the end of the month the Authority approves the disenrollment with the following exceptions:
(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;
(b) The Authority may retroactively disenroll the member if they have TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

STATUTORY/OTHER AUTHORITY: ORS 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3160

RULE TITLE: Integration and Care Coordination

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) In order to achieve the objectives of providing MCE members integrated person-centered care and services, MCEs shall 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 (CHA) and community health improvement plan (CHP).

(2) MCEs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.

(3) At a minimum, populations shall include members with special health needs, older adults, individuals who are blind, deaf, hard of hearing or with other disabilities, members who have complex medical needs, multiple chronic conditions, mental illness, or chemical dependency, or receive Medicaid-funded long-term care or long-term services and supports as defined in OAR 410-141-3000. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(4) Upon initial enrollment with the CCO, the MCE shall conduct an initial health risk screening for each new member, which is different from the assessment of special health care needs. This screening shall be completed and documented within 90 days of the effective date of enrollment for all new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. MCEs shall maintain documentation on the health risk screening process used for compliance. If the health risk screening requires additional information from the member, MCEs shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.

(5) MCEs shall have processes to ensure review of member’s potential need for long-term services and supports and identify appropriate members for referrals to DHS for long-term services and supports;

(6) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document in the member’s record and share the results of its health risk screening identifications appropriate for Intensive Care Coordination/Exceptional Needs Care Coordination (ICC/ENCC) services as defined in 410-141-3000:

(a) With participating medical providers serving the member;

(b) With the state or other MCEs serving the enrollee;

(c) With members receiving Medicaid-funded long-term care or long-term services and supports and their case manager and their LTSS provider, if approved by the member; and

(d) With Medicaid Advantage plans serving dual eligible members;

(e) Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(7) MCEs shall ensure that members assessed with high health needs, multiple chronic conditions, behavioral health issues, or receiving Medicaid funded long-term care or long-term services and supports are:

(a) Provided ICC services in accessing and managing appropriate preventive, health, behavioral health, remedial and

supportive care and services;
(b) Provided contact information for any ICC staff or formally designated person or entity with the primary responsibility for coordinating the services with the member;
(c) MCEs shall monitor subcontractors to ensure language and disability access are provided consistently across services and settings of care.
(8) For members with special health care needs determined through a health risk screening, MCEs shall have a process to allow enrollees direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.
(9) MCEs shall have processes to receive referrals for members receiving long-term care or long-term services and supports from DHS and referrals for intensive care coordination within 30 days, or as quickly as the member's health condition requires.
(10) MCEs shall produce a treatment or service plan for members with special health care needs, including members receiving LTC or LTSS that are determined through a health assessment to need a course of treatment or regular care monitoring:
(a) Such treatment plans shall be developed with any providers caring for the member, including any community-based support services and LTSS providers; and
(b) Include consultations with any specialist caring for the member and DHS long-term care or long-term services and supports, providers, or case managers:
(c) MCEs shall share information as needed to prevent duplication of efforts in assessments, care planning, and care coordination as follows:
(A)With DHS Aging and People with Disabilities and the Office of Developmental Disability Services case managers for members with Medicaid long-term care or long-term services and supports;
(B) Skilled nursing facilities when applicable;
(C) With other MCEs serving members; and
(D) With Medicare Advantage Plans serving dual eligible members.
(d) MCEs shall 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(i) State Plan Amendment and those receiving DHS Medicaid-funded long-term care services and supports. Plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals to ensure engagement and satisfaction and ensure authorization of services reflects rules outlined in OAR 410-141-3225 MCE Service Authorization.
(11) MCEs shall coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:
(a) With the services the enrollee receives from any other MCE;
(b) With the services the enrollee receives in FFS Medicaid; and
(c) With the services the enrollee receives from community and social support providers.
(12) MCEs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.
(13) To the maximum extent feasible, CCOs shall develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs:
(a) PCPCHs shall 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) MCEs shall 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) MCEs shall 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.

(14) If an MCE implements other models of patient-centered primary health care in addition to the use of PCPCH, the MCE shall ensure 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. The MCE shall:
(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 MCE participating provider type;
(b) Ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity;
(c) MCEs shall 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. MCEs shall ensure that all other services and supports are provided as close to the member's residence as possible:
(A) MCE members who are Indians (AI/AN) shall be permitted to select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE or may select an out-of-network IHCP from whom the enrollee is otherwise eligible to receive such primary care services;
(B) An out-of-network IHCP may refer an MCE member who is an Indian to an in-network provider without prior authorization or referral from a participating provider.
(d) MCEs shall maintain contracts with providers of residential chemical dependency treatment services and notify the Authority within 30 days of executing new contracts;
(e) MCEs shall maintain a contractual relationship with any dental care organizations necessary to provide adequate access to dental services in the area where members reside;
(f) MCEs shall assess the needs of its membership and make available supported employment and assertive community treatment services available when medically appropriate and when an appropriate provider is available. Appropriate providers are those that meet the requirements in OAR 309-019-0280. When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to make supported employment and assertive community treatment services available.
(15) MCEs shall have adequate, timely, and appropriate access to hospital and specialty services. MCEs shall 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.
(16) MCEs shall demonstrate how hospitals and specialty services shall be accountable to achieve successful transitions of care. MCEs 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.
(17) When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service or PHP to an MCE, the MCE 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 MCE participating provider.
(18) The MCE shall implement 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.

(19) For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), the MCE shall notify the appropriate DHS office and begin appropriate discharge planning. The MCE shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled in the MCE during the hospitalization preceding the nursing facility placement:
(a) MCEs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
(b) For members who are discharged to Medicare Skilled Care, the MCE shall notify the appropriate DHS office when the MCE 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;
(c) MCEs shall coordinate transitions to DHS Medicaid-funded long-term care services and supports, after the PHEC is exhausted, by communicating with local DHS offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care (LTC) settings.
(20) MCEs shall 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:
(a) The MCE 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 MCE services with long-term care services and crisis management services;
(b) MCEs 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 long-term care or long-term services and supports;
(c) MCEs 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.
(21) A CCO may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. (See OAR 410-141-3000 for the definition of an IMD.) The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):
(a) For members aged 21-64;
(b) As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
(c) The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
(A) The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
(B) The CCO must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
(C) The approved in lieu of services are authorized and identified in the CCO contract and may be offered to members at the CCO's option.
(22) 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 MCE shall communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services.
(23) An MCE shall 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).
(24) The MCE shall communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. MCEs shall document all monitoring and corrective action activities.
(25) MCEs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. MCEs shall coordinate the care of members that enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the state hospital and are transitioning from the Oregon State Hospital.
(26) MCEs shall coordinate a member's care even when services or placements are outside the MCE service area. MCE 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 MCE shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the MCE 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.
(27) Except as provided in OAR 410-141-3050, MCEs shall coordinate patient care, including care required by temporary residential placement outside the MCE service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon:
(a) MCE enrollment shall be maintained in the county of origin with the expectation of the MCE to coordinate care with the out of area placement and local providers;
(b) The MCE shall coordinate the discharge planning when the member returns to the county of origin.
(28) MCEs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the MCE's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The MCE shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3225 MCE Service Authorization.
(29) MCEs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional, as defined in OARs 410-120-0000, 410-141-3225, or 410-141-3240, and shall ensure a notice of action/adverse benefit determination notice is issued for an adverse benefit determination or service authorization denial, including request for referrals that are denied.
(30) MCEs 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.
(31) MCEs 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. This shall occur within 90 days or until the MCE can establish a relationship with the member and develop an evidence-based, medically appropriate coordinated care plan, whichever is later. The exception is when customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610–414.685

AMEND: 410-141-3170

RULE TITLE: Intensive Care Coordination (ICC) Services (Exceptional Needs Care Coordination (ENCC))

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) MCEs are responsible for intensive care coordination (ICC) services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the MCE uses another term, these rules set forth the elements and requirements for ICC services. Where the term ENCC appears in rule or contract, it shall be given the meaning in this rule.

(2) MCEs shall make ICC services available to members identified with special health care needs, older adults, individuals who are blind, deaf, hard of hearing or other disabilities, older adults, or members with complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those receiving Medicaid-funded long-term care or long-term services and supports receiving home and community-based services (HCBS) under the state's 1915(i), 1915(j), or 1915(k)State Plan Amendments or the 1915(c) HCBS waivers. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(3) The member, member's representative, HCBS provider, provider, or other medical personnel serving the member or the member's Medicaid Long Term Care (LTC) or Long Term Service and Supports (LTSS) case manager may refer or self-refer the member for a health risk screening for ICC services.

(4) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.

(5) Upon initial enrollment with the CCO, the MCE shall conduct an initial health risk screening for each new member, which is different from the assessment of special health care needs. This screening shall be completed and documented within 90 days of the effective date of enrollment for all new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. MCEs shall maintain documentation on the risk screening process used for compliance. If the risk screening requires additional information from the member, MCEs shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.

(6) MCEs shall have processes to ensure review of the member's potential need for long-term services and supports and identify appropriate members for referrals to DHS for long-term services and supports.

(7) MCEs shall implement procedures to share the results of its screening identifications and treatment plans appropriate for ICC services with participating providers serving the member and those identified in section (3). Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(8) MCEs shall implement an information sharing process to reduce duplication of services among entities serving members as follows:

(a) With DHS Aging and People with Disabilities and the Office of Developmental Disability Services Case Managers for members enrolled with Medicaid long-term care or long-term services and supports;

(b) With other MCEs serving members; and

(c) Skilled Nursing Facilities when applicable; and

(d) With Medicare Advantage plans serving dual eligible members.
(9) Such care coordination activities include:
(a) Early identification of members eligible for ICC services;
(b) Assistance to ensure timely access to medical providers and capitated services;
(c) Coordination with medical, LTC, and LTSS providers to ensure consideration is given to unique needs in treatment planning;
(d) Assistance to medical providers with coordination of capitated services and discharge planning; and
(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems;
(f) Subcontractors shall be monitored to ensure language and disability access are provided consistently across services and settings of care.
(10) MCEs shall implement processes for documentation of ICC services and the development of a treatment plan for a member identified with special health care needs.
(11) MCEs shall share treatment plan information as needed with DHS Aging and People with Disabilities and Office of Developmental Disability Services for members receiving Medicaid-funded long-term care or long-term services and supports, with other MCEs serving the member, and with Medicare Advantage plans serving dual eligible members. Each treatment plan shall be:
(a) Developed by the member's designated provider with the member's participation;
(b) Include consultations with any specialist caring for the member and DHS long-term services and supports providers and case managers;
(c) Approved by the MCE in a timely manner if MCE approval is required;
(d) In alignment with rules outlined in OAR 410-141-3225 MCE Service Authorization; and
(e) In accordance with any applicable quality assurance and utilization review standards.
(12) The member, member's representative, medical provider, other medical personnel serving the member, or the member's DHS case manager may request ICC services.
(13) MCEs shall have processes to receive referrals for health care assessments.
(14) MCEs shall refer members to ICC for a health assessment within 30 days when the member referred is receiving Medicaid LTSS or as quickly as the member's health condition requires.
(15) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.
(16) MCEs shall make ICC services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting.
(17) MCEs shall periodically inform all participating providers of the availability of ICC and other support services available for members and provide training for patient centered primary care homes and other primary care providers' staff.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3200

RULE TITLE: Outcome and Quality Measures

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) CCOs shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and HEDIS measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS.

(2) The contractor shall inform the Authority if it has been accredited by a private independent accrediting entity. If the contractor has been so accredited, the contractor shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review.

(3) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority. The measures are adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

(4) CCOs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral healthcare, oral health care, and all other health services provided by or under the responsibility of the CCO as specified in the CCO's contract with the Authority.

(5) CCOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the CCO's community health assessment, community health improvement plan, and the standards in the CCO's contract. CCOs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with CCO contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority;

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3245 through 410-141-3248; and

(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs, older adults, individuals who are blind, deaf, hard of hearing or with other disabilities, members who have complex medical needs, , multiple chronic conditions, mental illness, or chemical dependency; who receive Medicaid funded long-term care or long-term services and supports benefits as defined in OAR 410-141-3000; or who are children receiving CAF (Child Welfare) or OYA services.

(6) CCOs shall implement policies and procedures that assure it collects timely data including health disparities and other data required by rule or contract that allows the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(7) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 and the CCO contract that addresses assigned contractual responsibilities for physical health care, behavioral healthcare, or oral health care; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-3160; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.
(8) CCOs shall be accountable for both core and transformational measures of quality and outcomes:
(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts;
(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
(9) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the CCO agreement.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3320

RULE TITLE: Coordinated Care Organization Member Rights and Responsibilities

NOTICE FILED DATE: 05/10/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification on the following:

- CCO responsibility to provide coverage for Post Hospital Extended Care (PHEC) when appropriate.
- CCO and DHS responsibilities in Integration and Care Coordination & Intensive Care Coordination Services.
- Language relating to member rights to be free of restraint or seclusion used as a means for coercion, discipline, convenience, or retaliation.
- Requirements for CCOs to post drug lists on websites in a machine-readable format.
- References to the scope and role of External Quality Review Organizations (EQRO).

RULE TEXT:

(1) CCO members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

(b) Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;

(c) Choose a Primary Care Provider (PCP) or service site and to change those choices as permitted in the CCO's administrative policies;

(d) Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;

(e) Have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;

(f) Be actively involved in the development of their treatment plan;

(g) Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;

(h) Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;

(i) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(j) Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

(k) Receive culturally and linguistically appropriate services and supports in locations as geographically close to where members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

(L) Receive oversight, care coordination and transition and planning management from their CCO within the targeted population of the Division to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

(m) Receive necessary and reasonable services to diagnose the presenting condition;

(n) Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

(o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

(p) Receive assistance in navigating the health care delivery system and in accessing community and social support

services and statewide resources including but not limited to the use of certified or qualified health care interpreters advocates, community health workers, peer wellness specialists, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
(q) Obtain covered preventive services;
(r) Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;
(s) Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in the CCO's referral policy;
(t) Have a clinical record maintained that documents conditions, services received, and referrals made;
(u) Have access to one's own clinical record, unless restricted by statute;
(v) Transfer of a copy of the clinical record to another provider;
(w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
(x) Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
(y) Be able to make a complaint or appeal with the CCO and receive a response;
(z) Request a contested case hearing;
(aa) Receive certified or qualified health care interpreter services; and
(bb) Receive a notice of an appointment cancellation in a timely manner;
(cc) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
(2) CCO members shall have the following responsibilities:
(a) Choose or help with assignment to a PCP or service site;
(b) Treat the CCO, provider, and clinic staff members with respect;
(c) Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;
(d) Seek periodic health exams and preventive services from the PCP or clinic;
(e) Use the PCP or clinic for diagnostic and other care except in an emergency;
(f) Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
(g) Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in the CCO's referral policy;
(h) Give accurate information for inclusion in the clinical record;
(i) Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
(j) Ask questions about conditions, treatments, and other issues related to care that is not understood;
(k) Use information provided by CCO providers or care teams to make informed decisions about treatment before it is given;
(l) Help in the creation of a treatment plan with the provider;
(m) Follow prescribed agreed upon treatment plans and actively engage in their health care;
(n) Tell the provider that the member's health care is covered under the OHP before services are received and, if requested, show the provider the Division Medical Care Identification form;
(o) Tell the Department or Authority worker of a change of address or phone number;
(p) Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child;
(q) Tell the Department or Authority worker if any family members move in or out of the household;
(r) Tell the Department or Authority worker if there is any other insurance available;

(s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
(t) Pay the monthly OHP premium on time if so required;
(u) Assist the CCO in pursuing any third-party resources available and reimburse the CCO the amount of benefits it paid for an injury from any recovery received from that injury; and
(v) Bring issues or complaints or grievances to the attention of the CCO.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685