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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Upon filing.	
Adopted on	
01/01/2015 thru 06/29/2015	
Effective dates	

RULE CAPTION

Rewrite Enrollment Rules to Reflect Current Enrollment Practices Including Full Pregnancy Enrollment Exemption process.

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-0060, 410-141-3060

SUSPEND:

Stat. Auth.: ORS 413.042, 414.615, 414.635, 414.651

Other Auth.:

Stats. Implemented: ORS 414.610 - 414.685

RULE SUMMARY

The Division rewrote OAR 410-141-3060 and OAR 410-141-0060 to better align the MCO and CCO enrollment and to reflect current enrollment practices. In those changes the Authority has specified its pregnancy enrollment exemption protocols, as specified by agreement between Authority leadership and the Licensed Direct Entry Midwives. The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. OHA Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating DMAP would implement changes, necessitating the removal of

the sunset date, allowing for time to make further program implementations and additional rule revisions.

STATEMENT OF NEED AND JUSTIFICATION

The temporary amendment of OAR 410-141-0060 and OAR 410-141-3060

In the Matter of

- The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. OHA Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating DMAP would implement changes, necessitating the removal of the sunset date, allowing for time to make further program implementations and additional rule revisions.

- Minutes from the May 27, 2014 Medical Management Committee meeting. Minutes are available through DMAP.

Documents Relied Upon, and where they are available

The Division needs to rewrite OAR 410-141-3060 and OAR 410-141-0060 to better align the MCO and CCO enrollment and to reflect current enrollment practices. In those changes the Authority has specified its pregnancy enrollment exemption protocols.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to public interest, to the interest of DMAP clients, the Division, and providers. The Division needs to act promptly to ensure the third trimester pregnancy enrollment exemption included in OAR 410-141-3060 correctly reflects the appropriate changes. It is necessary to use the temporary rule process to reflect those changes in a timely manner.

Justification of Temporary Rules

Authorized Signer	Printed Name	Date
Rhonda Busch	Rhonda Busch	12-3-14

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

Secretary of State

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division) 410

Agency and Division Administrative Rules Chapter Number

In the Matter of: The temporary amendment of OAR 410-141-0060 and OAR 410-141-3060

RULE CAPTION

Rewrite Enrollment Rules to Reflect Current Enrollment Practices Including Full Pregnancy Enrollment Exemption process.

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

Statutory Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651

Other Authority:

Stats. Implemented: ORS 414.610—414.685

Need for the Temporary Rule(s): The Division needs to rewrite OAR 410-141-3060 and OAR 410-141-0060 to better align the MCO and CCO enrollment and to reflect current enrollment practices. In those changes the Authority has specified its pregnancy enrollment exemption protocols.

Documents Relied Upon, and where they are available:

- The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. OHA Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating DMAP would implement changes, necessitating the removal of the sunset date, allowing for time to make further program implementations and additional rule revisions.
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Justification of Temporary Rule(s): The Authority finds that failure to act promptly will result in serious prejudice to public interest, to the interest of DMAP clients, the Division, and providers. The Division needs to act promptly to ensure the *third trimester pregnancy enrollment exemption* included in OAR 410-141-3060 correctly reflects the appropriate changes. It is necessary to use the temporary rule process to reflect those changes in a timely manner.

Authorized Signer Printed name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

~~OAR 410-141-0060~~

~~Oregon Health Plan Managed Care Enrollment Requirements~~

~~(1) Enrollment of an Oregon Health Plan (OHP) client, excluding the Health Plan New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) clients in prepaid health plans (PHPs) shall be mandatory unless exempted from Enrollment by the Oregon Health Authority (Authority), or unless the OHP client resides in a service area where there is inadequate capacity to provide access to capitated services for all OHP clients through PHPs or primary care managers (PCMs).~~

~~(2) Enrollment of the HPN and CHIP clients in PHPs shall be mandatory unless exempted from Enrollment by the Authority under the terms in section (4) of this rule. Selection of PHPs in accordance with this rule is a condition of eligibility for HPN and CHIP clients. If, upon reapplication, HPN or CHIP Clients do not select PHPs in accordance with this rule, PHPs will be selected by the Authority. This selection will be based on which PHPs the HPN or CHIP clients were previously enrolled in.~~

~~(3) OHP clients, except HPN and CHIP clients shall be enrolled with PHPs or PCMs according to the following criteria:~~

~~(a) Areas with sufficient physical health service capacity through a combination of Fully Capitated Health Plans (FCHP), Physician Care Organizations (PCO), and PCMs shall be called mandatory FCHP/PCO/PCM service areas. In mandatory FCHP/PCO/PCM service areas, an OHP client shall select:~~

~~(A) An FCHP or PCO; or~~

~~(B) A PCM if exempt from FCHP or PCO enrollment.~~

~~(b) Service areas with sufficient physical health service capacity through PCMs alone shall be called mandatory PCM service areas. An OHP client shall select a PCM in a mandatory PCM service area;~~

~~(c) Service areas without sufficient physical health service capacity through FCHPs, PCOs and PCMs shall be called voluntary FCHP/PCO/PCM service areas. In voluntary FCHP/PCO/PCM service areas, an OHP client may choose to:~~

~~(A) Select any FCHP, PCO or PCM that is open for enrollment; or~~

~~(B) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.~~

~~(d) Service areas with sufficient dental care service capacity through DCOs shall be called mandatory DCO service areas. An OHP client shall select a DCO in a mandatory DCO service area;~~

~~(e) Service areas without sufficient dental care service capacity through DCOs shall be called voluntary DCO service areas. In voluntary DCO service areas, an OHP client may choose to:~~

~~(A) Select any DCO open for enrollment; or~~

~~(B) Remain in the Medicaid FFS dental care delivery system;~~

~~(f) Service areas with sufficient mental health service capacity through MHOs shall be called mandatory MHO service areas.OHP clients will be enrolled in an MHO in a mandatory MHO service area;~~

~~(g) Service areas without sufficient mental health service capacity through MHOs shall be called voluntary MHO service areas. An OHP client may choose to select an MHO in voluntary MHO service areas if the MHO is open for enrollment, or may choose to remain in the Medicaid FFS mental health care delivery system;~~

~~(h) When a service area changes from mandatory to voluntary, the Division member will remain with their PHP for the remainder of their eligibility period, unless the Division member meets the criteria stated in section (4) of this rule, or as provided by OAR 410-141-0080.~~

~~(4) The following are exemptions to mandatory enrollment in PHPs that allow OHP clients, including HPN and CHIP clients, to enroll with a PCM or remain in the Medicaid FFS delivery systems for physical, dental and/or mental health care:~~

~~(a) The OHP client is covered under a major medical insurance policy, such as a Medicare supplemental policy, Medicare employer group policy or other third party resource (TPR) which covers the cost of services to be provided by a PHP, (excluding dental insurance. An OHP client shall be enrolled with a DCO even if they have a dental TPR). The OHP client shall enroll with a PCM if the insurance policy is not a private HMO;~~

~~(b) Clients who meet all of the criteria listed in section (4)(b)(A) through (C) are exempt from mandatory enrollment:~~

~~(A) The OHP client has an established relationship with a Division enrolled practitioner from whom the client receives ongoing treatment for a covered medical or dental condition, and;~~

~~(B) Subject to OAR 410-141-0080(1)(b)(B)(vi)(III), the Divison enrolled practitioner is not a member of the PHP's participating provider panel the OHP client would be enrolled in, and;~~

~~(C) Loss of continuity of care for the covered medical or dental condition would have a significant negative effect on the health status of the OHP client, as determined by the~~

~~Authority through medical review, to change practitioners and receive treatment from the PHP's participating provider panel;~~

~~(D) When the practitioner is a primary care practitioner (PCP) enrolled with the Division as a PCM, the OHP client shall enroll with this practitioner as a PCM member;~~

~~(E) Exemptions from mandatory enrollment in PHPs for this reason may be granted for a period of four months. Extensions may be granted by the Authority upon request, subject to review of unique circumstances. A 12-month exemption may be granted if the reason for the exemption is not likely to change or is due to a chronic or permanent condition or disability;~~

~~(c) OHP clients shall be exempted from mandatory Enrollment with an FCHP or PCO, if the OHP client became eligible through a hospital hold process and are placed in the Adults/Couples category. The OHP client shall remain FFS for the first six (6) months of eligibility unless a change occurs with their eligibility or the category. At that time, the exemption shall be removed and the OHP Client shall be enrolled into an open FCHP or PCO. The exemption shall not affect the mandatory enrollment requirement into a DCO or MHO.~~

~~(d) The OHP client is a Native American or Alaska Native with Proof of Indian Heritage and chooses to receive services from an Indian Health Service facility or tribal health clinic;~~

~~(e) The OHP client is a child in the legal custody of either the Oregon Youth Authority (OYA) or Children, Adults and Families (CAF) (Child Welfare Services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless:~~

~~(A) There is no FFS access; or~~

~~(B) There are continuity of care issues.~~

~~(f) The OHP client is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination, and she wishes to continue obtaining maternity services from a practitioner who is not a participating provider with an FCHP or PCO in the Service Area.~~

~~(A) In order to qualify for such exemption at the time of redetermination, the OHP client must not have been enrolled with an FCHP or PCO during the three months preceding redetermination;~~

~~(B) If the Division member moves out of her PHP's service area during the third trimester, the Division member may be exempted from enrollment in the new service area for continuity of care if the Division member wants to continue obstetric care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-0220;~~

~~(C) If the practitioner is a PCM, the Division member shall enroll with that practitioner as a PCM member;~~

~~(D) If the practitioner is not enrolled with the Division as a PCM, then the Division member may remain in the Medicaid FFS delivery system until 60 days after the birth of her child. After the 60-day period, the OHP client must enroll in a FCHP or PCO.~~

~~(g) The OHP client has End Stage Renal Disease (ESRD). The OHP client shall not enroll in an FCHP or PCO but shall enroll with a PCM unless exempt for some other reason listed in section (4) of this rule;~~

~~(h) The OHP client has been accepted by the Medically Fragile Children's Unit of the Addictions and Mental Health Division (AMH);~~

~~(i) An OHP client who is also a Medicare beneficiary and is in a hospice program shall not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The OHP client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan or with a PCM unless exempt for some other reason listed in section (4) of this rule;~~

~~(j) The OHP client is enrolled in Medicare and the only FCHP or PCO in the Service Area is a Medicare Advantage plan. The OHP client may choose not to enroll in an FCHP or PCO;~~

~~(k) Other just causes as determined by the Authority through medical review, which include the following factors:~~

~~(A) The cause is beyond the control of the OHP client;~~

~~(B) The cause is in existence at the time that the OHP client first becomes eligible for OHP;~~

~~(C) Enrollment would pose a serious health risk; and~~

~~(D) The lack of reasonable alternatives.~~

~~(l) A woman eligible for the Breast and Cervical Cancer Medical (BCCM) Program, (refer to BCCM rules established by CAF), shall not enroll in an FCHP, PCO, DCO or MHO. A woman in the BCCM Program shall remain in the Medicaid FFS delivery system.~~

~~(5) The primary person in the household group and benefit group as defined in OAR 461-110-0110, 461-110-0210, and 461-110-0720, respectively, shall select PHPs or PCMs on behalf of all OHP clients in the benefit group. PHP or PCM selection shall occur at the time of application for OHP in accordance with section (1) of this rule:~~

~~(a) All OHP clients in the benefit group shall enroll in the same PHP for each benefit type (physical, dental or mental health care) unless exempted under the conditions stated in section (4) of this rule. If PCM selection is an option, OHP clients in the benefit group may select different PCMs;~~

~~(b) If the OHP client is not able to choose PHPs or PCMs on his or her own, the representative of the OHP client shall make the selection. The hierarchy used for making enrollment decisions shall be in descending order as defined under representative:~~

~~(A) If the Medicare Advantage Plan Election form (OHP 7208M), described in subsection (5)(d) of this rule, is signed by someone other than the OHP client, the OHP client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M.~~

~~(B) If the OHP client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative shall not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components.~~

~~(c) CAF or OYA shall select PHPs or a PCM for a child receiving CAF (Child Welfare Services) or OYA services, with the exception of children in subsidized adoptions;~~

~~(d) Enrollment in a FCHP or PCO of an OHP client who is receiving Medicare and who resides in a service area served by PHPs or PCMs shall be as follows:~~

~~(A) If the OHP client, who is Medicare Advantage eligible, selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the OHP client shall complete the 7208M, or other CMS approved Medicare plan election form:~~

~~(i) If the FCHP or PCO has not received the form within 10 calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the Division member with a copy sent to APD branch manager. The letter shall:~~

~~(I) Explain the need for the completion of the form;~~

~~(II) Inform the Division member that if the form is not received within 30 days, the FCHP or PCO may request disenrollment; and~~

~~(III) Instruct the Division 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 OHP 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 must notify the PHP Coordinator of the PHP's annual decision to disenroll or maintain Enrollment for the OHP clients in~~

~~writing. This notification must be submitted by January 31 of each year, or another date specified by the Division. If the FCHP or PCO has decided to:~~

~~(I) Disenroll the OHP clients and has not received a Division client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the Division member effective the end of the month following the notification.~~

~~(II) Maintain enrollment, the FCHP or PCO shall not request disenrollment at the end of 30 days.~~

~~(B) If the OHP client is enrolled as a private member of a Medicare Advantage plan, the OHP 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:~~

~~(i) If the OHP client chooses to remain as a private member in the Medicare Advantage plan, the OHP client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;~~

~~(ii) If the OHP 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 OHP client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other OHP clients;~~

~~(iii) A Fully Dual Eligible (FDE) OHP client who has been exempted from enrollment in an MHO shall 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.~~

~~(e) MHO Enrollment options shall be based on the OHP client's county of residence, the FCHP or PCO selected by the OHP client, and whether the FCHP or PCO selected serves as a MHO:~~

~~(A) If the OHP client selects a FCHP or PCO that is not a MHO, then the OHP client shall enroll in the MHO designated as the freestanding MHO for that county;~~

~~(B) If the OHP client selects a FCHP or PCO that is a MHO, then the OHP client shall receive OHP mental health benefits through that FCHP or PCO.~~

~~(6) If the OHP client resides in a mandatory service area and fails to select a DCO, MHO, PCO and/or FCHP or a PCM at the time of application for the OHP, the Division may enroll the OHP client with a DCO, MHO, PCO and/or FCHP or a PCM as follows:~~

~~(a) The OHP client shall be assigned to and enrolled with a DCO, MHO, and FCHP, PCO or PCM which meet the following requirements:~~

(A) Is open for enrollment;

(B) Serves the county in which the OHP client resides;

(C) Has practitioners located within the community standard distance for average travel time for the OHP client.

(b) Assignment shall be made first to a FCHP or PCO and second to a PCM;

(c) The Authority shall send a notice to the OHP client informing the OHP 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, and FCHP, PCO or PCM open for enrollment in the county in which the OHP client resides;

(d) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the OHP client and notifies the OHP client of enrollment and the name of the PHP or PCM: If enrollment is initiated by a Authority worker on or before Wednesday, the date of Enrollment shall be the following Monday. If enrollment is initiated by a 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 FCHP, PCO, MHO 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.

(7) The provision of capitated services to a Division member enrolled with a PHP or a PCM shall begin on the first day of enrollment with the PHP or a PCM 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 with a FCHP, PCO or MHO shall be the first possible Enrollment date after the date the OHP client is discharged from inpatient hospital services and the date of Enrollment with a PCM shall be the first of the month for which capitation payment is made;

(c) For Division members who are re-enrolled within 30 calendar days of disenrollment. The date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;

(d) Adopted children or children placed in an adoptive placement. The date of enrollment shall be the date specified by the Authority.

410-141-3060

~~Enrollment Requirements in a CCO~~

~~(1) A client who is eligible for or receiving health services must enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and 414.632(2) or exempted by this rule.~~

~~(2) If, upon application or redetermination, a client does not select a CCO, the Authority shall enroll the client and the client's household in a CCO that has adequate health care access and capacity.~~

~~(3) For existing members of a PHP that has transitioned to a CCO, the Authority shall enroll those members in the CCO when the Authority certifies and contracts with the CCO. The Authority shall provide notice to the enrollees 30 days before the effective date.~~

~~(4) Existing members of a PHP that is on the path to becoming a CCO shall retain those members. The Authority shall enroll those members in the CCO when certification and contracting are complete. The Authority shall provide notice to the clients 30 days before the effective date.~~

~~(5) Unless otherwise exempted by sections (17) and (18) of this rule, existing clients receiving their physical health care services on a fee-for-service (FFS) basis shall enroll in a CCO serving their area that has adequate health care access and capacity. They must enroll by November 1, 2012. The Authority shall send a notice to the clients 30 days before the effective date.~~

~~(6) The following apply to clients receiving physical health care services on a fee-for-service basis but managed or coordinated behavioral health services:~~

~~(a) The Authority shall enroll the client in a CCO that is serving the client's area before November 1, 2012;~~

~~(b) The client shall receive their behavioral health care services from that CCO;~~

~~(c) The client shall continue to receive their physical health care services on a fee-for-service basis; and~~

~~(d) On or after November 1, 2012, the Authority shall enroll the client in a CCO for both physical health and behavioral health care services, unless otherwise exempted by sections (17) and (18) of this rule.~~

~~(e) On or after November 1, 2012, for the client exempt from coordinated physical health services by sections (17) and (18) shall receive managed or coordinated behavioral health services from a CCO or MHO.~~

~~(7) The following apply to clients enrolled in Medicare:~~

~~(a) A client may 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, may shall enroll in a CCO, even if the CCO does not have a corresponding Medicare Advantage plan.~~

~~(c) A client may shall 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 may shall enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.~~

~~(8) From August 1, 2012, until November 1, 2012, enrollment is required in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. The following outlines the priority of enrollment during this period in service areas where enrollment is required:~~

~~(a) Priority 1: The client must shall enroll in a CCO that serves that area and has adequate health care access and capacity;~~

~~(b) Priority 2: The client must shall enroll in a PHP if:~~

~~(A) A PHP serves an area that a CCO does not serve; or~~

~~(B) A PHP serves an area that a CCO serves, but the CCO has inadequate health care access and capacity to accept new members;~~

~~(c) Priority 3: The client shall receive services on a fee-for-service basis.~~

~~(9) From August 1, 2012, until November 1, 2012, enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP. If a client decides to enroll in a CCO or PHP, the priority of enrollment in section (8) applies.~~

~~(10) On or after November 1, 2012, CCO enrollment is required in all areas. The following outlines the priority of options to enroll in all service areas:~~

~~(a) Priority 1: The client must shall enroll in a CCO that serves that area and has adequate health care access and capacity;~~

~~(b) Priority 2: The client must shall enroll in a PHP on the path to becoming a CCO if:~~

~~(A) The PHP serves an area that a CCO does not serve; or~~

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members;

(c) Priority 3: The client must shall enroll in a PHP that is not on the path to becoming a CCO if:

(A) The PHP serves an area that a CCO does not serve; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care access or capacity to accept new members;

(d) Priority 4: The client shall receive physical services on a fee-for-service basis.

(11) On or after July 1, 2013, a client must shall enroll in a CCO or managed dental care organization (DCO) in a service area where a CCO or DCO has adequate dental care access and capacity, and a CCO or DCO is open to enrollment.

a client receives physical health care through a PHP, PCM, or on a fee-for-service basis, under circumstances allowed by this rule, the client must shall enroll in a CCO or mental (behavioral) health organization (MHO) in a service area where MHO enrollment is required. The following determines if a service area requires CCO or MHO enrollment:

(a) CCO: The service area has adequate CCO behavioral health care access and capacity;

(b) MHO: A CCO does not serve in the area; or

(c) MHO: A CCO serves the area, but the CCO has inadequate health care access and capacity to accept new members:

(1213) From August 1, 2012, until November 1, 2012, if a service area changes from required 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 410-41-3080.

(13) At the time of application or recertification, the primary person in the household shall select the CCO on behalf of all household members on the same household case. If the client is not able to choose a CCO, the client's representative shall make the selection.

(14) The Department or OYA shall select the CCO for a child in the legal custody of the Department or OYA, except for children in subsidized adoptions.

(15) The following populations are exempt from CCO enrollment:

~~(a) Populations expressly exempted by ORS 414.631(2) (a), (b) and (c), which includes:~~

~~(A) Persons who are non-citizens who are eligible for labor and delivery services and emergency treatment services;~~

~~(B) Persons who are American Indian and Alaskan Native beneficiaries; and~~

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

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

~~(c) Children in the legal custody of the Department or OYA 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 fee-for-service basis is not available; or~~

~~(B) Enrollment would preserve continuity of care.~~

~~(d) Clients with major medical health insurance coverage, also known as third party liability, except as provided in OAR 410-141-3050;~~

~~(e) Clients receiving prenatal services through the Citizen/Alien Waivered-Emergency Medical program; and~~

~~(f) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs.~~

~~(16) The following populations are exempt from CCO enrollment until specified below:~~

~~(a) From August 1, 2012, until November 1, 2012, children under 19 years of age who are medically fragile and who have special health care needs. Beginning November 1, 2012, 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) Until July 1, 2014women~~ Women ~~who are in their third trimester of pregnancy when first determined eligible for OHP or at re-determination may qualify as identified below to receive OHP benefits on a F~~f~~ee-for-s~~S~~ervice (FFS) basis until 60 days after the birth of her child. After the 60 day period the OHP member must~~ shall ~~enroll in a CCO. In order to qualify for the FFS third trimester exemption the member must:~~

~~(A) Not have been enrolled with a service area CCO, FCHP$_1$ or PCO during the three months preceding re-determination,~~

~~(B) Have an established relationship with a licensed qualified practitioner who is not a participating provider with the service area CCO, FCHP$_1$ or PCO and wishes to continue obtaining maternity services from the non-participating provider on a FFS basis, and~~

~~(C) Make a request to change to FFS prior to the date of the delivery if enrolled with a CCO, FCHP$_1$ or PCO.~~

~~(c) From August 1, 2012 until November 1, 2012, clients receiving health care services through the Breast and Cervical Cancer Program are exempt. Beginning November 1, 2012, enrollment is required;~~

~~(d) Existing clients who had organ transplants are exempt until the Authority enrolls them in a CCO on a case-by-case basis; and~~

~~(e) From August 1, 2012, until November 1, 2012, clients with end-stage renal disease. Beginning November 1, 2012, enrollment is required.~~

~~(17) The following clients who are exempt from CCO enrollment and who receive services on a fee-for-service basis may enroll in a CCO:~~

~~(a) Clients who are eligible for both Medicare and Medicaid;~~

~~(b) Clients who are American Indian and Alaskan Native beneficiaries;~~

~~(18) The Authority may exempt clients or 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. Other just causes include the following considerations:~~

~~(a) Enrollment would pose a serious health risk; and~~

~~(b) The Authority finds no reasonable alternatives.~~

~~(19) 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.~~

~~(20) Coordinated care services shall begin on the first day of enrollment with the CCO except for:~~

~~(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;~~

~~(b) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;~~

~~(c) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.~~

~~Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, and & 414.651~~

~~Stats. Implemented: ORS 414.610 – 414.685~~

410-141-0060 **RULE REWRITTEN**

Oregon Health Plan Managed Care Enrollment Requirements

(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) Until December 31, 2017, 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 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.

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610, 414.685

410-141-3060 **RULE REWRITTEN**

Enrollment Requirements in a CCO

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

(a) *Client* means an individual found eligible to receive OHP 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 410-120-000**0;**

(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 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 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 ORS 414.631 and except as provided for children in Child Welfare through the BRS and 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) Until December 31, 2017, 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 A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there must be no home birth option available to the client through her plan and the client must:

(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 CCO; and

(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 CCO 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 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;

(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 stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services must 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 will be FFS unless already established with a PHP's provider;

(c) Priority 3: The client shall receive services on a 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 will 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 for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time 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 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.

(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610, 414.685