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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

02/01/2014 thru 07/31/2014

Effective dates

RULE CAPTION

Add Without Cause to CCO, FCHP, PCO and DCO Disenrollment Criteria Pursuant to
Federal Regulations

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-0080, 410-141-3080

SUSPEND:

Stat. Auth.: ORS 413.032, 413.042, 414.615, 414.625, 414.635, 414.651

Other Auth.:

Stats. Implemented: ORS 414.065, 414.610 through 414.685

RULE SUMMARY

The Division needs to amend these rules to modify the Oregon Health Plan member 'without cause' disenrollment language. This change will align with federal regulations, 42 CFR 438.56(c)(2), which allows flexibility and choice for members.

This rule revision is needed immediately to assist the Coordinated Care Organizations (CCO), the Physician Care Organizations (PCO), the Fully Capitated Health Plans (FCHP) and the Dental Care Organizations (DCO) with facilitation of disenrollment requests made to the Authority.

The Division is amending these rules to comply with federal requirements and allow members to disenroll from a CCO, FCHP, PCO or DCO based on a 'without cause' criteria.

STATEMENT OF NEED AND JUSTIFICATION

Temporary Amendment of OAR 410-141-0080 and 410-141-3080

In the Matter of

42 CFR 438.56

Documents Relied Upon, and where they are available

The Division needs to amend these rules to modify the "without cause" disenrollment language for Coordinated Care Organization (CCO), Physician Care Organization (PCO), and Dental Care Organization (DCO), and Fully Capitated Health Plan (FCHP) members. This change will align with federal regulations, 42 CFR 438.56(c)(2), which allows flexibility and choice for members. The Division is amending these rules to comply with federal requirements and allow members to disenroll managed and coordinated care organizations based on "without cause" criteria.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, CCOs, FCHPs, PCOs, DCOs and their members. These rules need to be adopted promptly so that members may disenroll from managed and coordinated care organizations without cause and to provide guidance to CCO's, FCHPs, PCOs and DCO's regarding the new criteria. This rule revision is needed immediately to assist the organizations with facilitation of disenrollment requests made to the Authority. The Authority needs to adopt these rules promptly to be in compliance with Federal Regulations.

Justification of Temporary Rules

Rhonda Busel

Authorized Signer

Rhonda Busel

Printed Name

1-31-2014

Date

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)
Agency and Division

410

Administrative Rules Chapter Number

In the Matter of: Temporary Amendment of OAR 410-141-0080 and 410-141-3080

Rule Caption: Add "Without Cause" to CCO, FCHP, PCP & DCO Disenrollment Criteria Pursuant to Federal Regulations

Statutory Authority: ORS 413.032, 413.042, 414.615, 414.625, 414.635 and 414.651

Other Authority: None

Stats. Implemented: ORS 414.065 and 414.610 through 414.685

Need for the Temporary Rule(s):

The Division needs to amend these rules to modify the "without cause" disenrollment language for Coordinated Care Organization (CCO), Physician Care Organization (PCO), and Dental Care Organization (DCO), and Fully Capitated Health Plan (FCHP) members. This change will align with federal regulations, 42 CFR 438.56(c)(2), which allows flexibility and choice for members.

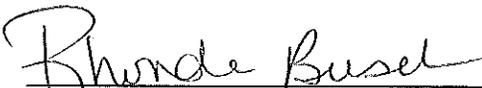
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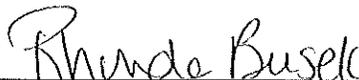
Documents Relied Upon, and where they are available: 42 CFR 438.56

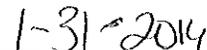
Justification of Temporary Rule(s):

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, CCOs, FCHPs, PCOs, DCOs and their members. These rules need to be adopted promptly so that members may disenroll from managed and coordinated care organizations without cause and to provide guidance to CCO's, FCHPs, PCOs and DCO's regarding the new criteria. This rule revision is needed immediately to assist the organizations with facilitation of disenrollment requests made to the Authority.

The Authority needs to adopt these rules promptly to be in compliance with Federal Regulations.


Authorized Signer


Printed name


Date

410-141-0080

Managed Care Disenrollment from Prepaid Health Plans

For purposes of this rule Managed Care Prepaid Health Plan means Fully Capitated Health Plan, Dental Care Organization, Physician Care Organization and Mental Health Organization.

(1) All Oregon Health Plan (OHP) Division member-initiated requests for disenrollment from a Prepaid Health Plan (PHP) must be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For Division members who are not able to request disenrollment on their own, the request may be initiated by the Division member's Representative.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority and PHP shall honor a Division member or Representative requests for disenrollment for the followingshall be honored:

(a) Without cause:

(iA) Newly eligible clients may change their PHP assignment within 90 days following the date After six months of Division member's initial enrollment. The effective date of disenrollment shall be the first of the month following the Department'sDivision's approval of disenrollment;

(ii) At least once every 12 months;

(iii) Existing members may change their PHP assignment within 30 days of the Authority's automatic assignment or reenrollment in a PHP;

~~(B) Whenever a Division member's eligibility is redetermined by the Department of Human Services (Department) and the primary person requests disenrollment without cause. The effective date of disenrollment shall be the first of the month following the date that the Division member's eligibility is redetermined by the Department;~~

(ivG) Effective retroactively on or after September 1, 2011 and in accordance with SB 2201 and the Division's determination, Division members mayhave the right to disenroll from a PHPFGHP or PGO during their redetermination (enrollment period), or one additional time during their enrollment period based on the members choice and with Authority approval. The disenrollment shall be considered "recipient choice".

~~into another FCHP or PCO during their redetermination or enrollment period in, accordance with OAR 410-141-0060, or one additional time during their enrollment period based on the Division member's choice and with OHA approval.~~

(b) With cause:

(A) At any time;

(B) Division members who disenroll from a Medicare Advantage plan shall also be disenrolled from the corresponding Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). The effective date of disenrollment shall be the first of the month that the Division member's Medicare Advantage plan disenrollment is effective;

(C) Division members who are receiving Medicare and who are enrolled in a FCHP or PCO that has a corresponding Medicare Advantage component may disenroll from the FCHP or PCO at any time if they also request disenrollment from the Medicare Advantage plan. The effective date of disenrollment from the FCHP or PCO shall be the first of the month following the date of request for disenrollment;

(D) PHP does not, because of moral or religious objections, cover the service the Division member seeks;

(E) The Division 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 Division members' Primary Care Provider or another Provider determines that receiving the services separately would subject the Division member to unnecessary risk; or

(F) 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 experienced in dealing with the Division member's health care needs. Examples of sufficient cause include but are not limited to:

(i) The Division member moves out of the PHP's Service Area;

(ii) The Division 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 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any Oregon Health Plan client 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 Oregon Health Plan

client 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 PHP;

(iv) If 500 or more Division members choose to change plans in order to continue receiving care from a provider that is terminating their contractual relationship with a PHP, the Division shall send all of the Division Members a written notice 90 days in advance of the termination date;

(I) The member and all family (case) members shall be transferred to the provider's new PHP;

(II) The transfer shall take effect when the provider's contract with their current PHP contractual relationship ends, or on a date approved by the Division.

(c) If the following conditions are met:

(A) The applicant is in the third trimester of her pregnancy and has just been determined eligible for OHP, or the OHP client has just been re-determined eligible and was not enrolled in a FCHP or PCO within the past 3 months; and

(B) The new FCHP or PCO the Division member is enrolled with does not contract with the Division member's current OB Provider and the Division member wishes to continue obtaining maternity services from that Non-Participating OB Provider; and

(C) The request to change FCHPs, PCOs or return to FFS is made prior to the date of delivery.

(d) Division member disenrollment requests are subject to the following requirements:

(A) The Division member shall join another PHP, unless the Division member resides in a Service Area where enrollment is voluntary, or the Division member meets the exemptions to enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory Service Area is the PHP from which the Division member wishes to disenroll, the Division member may not disenroll without cause;

(C) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless retroactive disenrollment is approved by the Division;

(D) If the Department fails to make a disenrollment determination by the first day of the second month following the month in which the Division member files a request for disenrollment, the disenrollment is considered approved.

(3) Prepaid Health Plan requests for disenrollment:

(a) Causes for disenrollment:

(A) The Division may disenroll Division members for cause when requested by the PHP, subject to American with Disabilities Act requirements. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of missed appointments is to be established by the Provider or PHP. The number must be the same as for commercial members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the Division member in receiving services. This rule does not apply to Medicare members who are enrolled in a FCHP's or PCO's Medicare Advantage plan;

(ii) Division member's behavior is disruptive, unruly, or abusive to the point that his/her continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either the Division member or other members, subject to the requirements in (3)(a)(B)(vii);

(iii) Division member commits or threatens an act of physical violence directed at a medical Provider or property, the Provider's staff, or other patients, or the PHP's staff to the point that his/her continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular Division member or other Division members, subject to the requirements in (3)(a)(B)(vii);

(iv) Division member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts (other than those addressed in (3)(a)(A)(ii) or (iii)) committed in any Provider or PHP's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) Fraud Unit as appropriate;

(v) OHP clients who have been exempted from mandatory enrollment with a FCHP or PCO, due to the OHP client's eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060(4)(b)(F);

(vi) Division member fails to pay co-payment(s) for Covered Services as described in OAR 410-120-1230.

(B) Division members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

(ii) Because of an adverse change in the Division member's health;

(iii) Because of the Division member's utilization of services, either excessive or lack thereof;

(iv) Because the Division member requests a hearing;

(v) Because the Division member has been diagnosed with End Stage Renal Disease (ESRD);

(vi) Because the Division member exercises his/her option to make decisions regarding his/her medical care with which the PHP disagrees;

(vii) Because of uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the Division member's special needs (except when continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this Division member or other members).

(C) Requests by the PHP for disenrollment of specific Division members shall be submitted in writing to their PHP Coordinator for approval. The PHP must 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 must be followed prior to requesting disenrollment of a Division member:

(i) There shall be notification from the Provider to the PHP at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the PHP. Such notification shall be documented in the Division member's Clinical Record. The PHP shall conduct Provider education regarding the need for early intervention and the services they can offer the Provider;

(ii) The PHP shall contact the Division member either verbally or in writing, depending on the severity of the problem, to inform the Division member of the problem that has been identified, and attempt to develop an agreement with the Division member regarding the issue(s). If contact is verbal, it shall be documented in the Division member's record. The PHP shall inform the Division member that his/her continued behavior may result in disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other interventions with the Division member in a serious effort to resolve the problem;

(iv) The PHP shall contact the Division member's Department caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution, within the laws governing confidentiality;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of the Provider, caseworker, Division member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain an authorization for release of information from the Division member for the Providers and

agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the Division member's record;

(vi) Any additional information or assessments requested by the Division PHP Coordinator;

(vii) If the Division member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, as the result of his/her special needs or disability, the PHP must also document each of the following:

(I) A written assessment 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 Division member poses a direct threat to the health or safety of others, the PHP must 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 PHP-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist or other health care professionals who have the appropriate clinical expertise in treating the Division 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;

(V) Documentation of the PHP's rationale for concluding that the Division member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular Division member or other members.

(viii) If a Primary Care Provider (PCP) terminates the Provider/patient relationship, the PHP shall attempt to locate another PCP on their panel who will accept the Division member as their patient. If needed, the PHP shall obtain an authorization for release of information from the Division member in order to share the information necessary for a new Provider to evaluate if they can treat the Division member. All terminations of Provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP or PCP's policies for commercial members.

(D) Requests shall be reviewed according to the following process:

(i) If there is sufficient documentation, the request shall be evaluated by the PHP's Coordinator or a team of PHP Coordinators who may request additional information from Ombudsman Services, AMH or other agencies as needed; If the request involves the Division member's mental health condition or behaviors related to substance abuse, the PHP Coordinator should also confer with the OHP Coordinator in AMH;

(ii) If there is not sufficient documentation, the PHP Coordinator shall notify the PHP within 2 business days of what additional documentation is required before the request can be considered;

(iii) The PHP Coordinators shall review the request and notify the PHP of the decision within ten working days of receipt of sufficient documentation from the PHP. Written decisions, including reasons for denials, shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the PHP.

(E) If the request is approved the PHP Coordinator must send the Division member a letter within 14 days after the request was approved, with a copy to the PHP, the Division member's Department caseworker and Division's Health Management Unit (HMU). The letter must give the disenrollment date, the reason for disenrollment, and the notice of Division member's right to file a Complaint (as specified in 410-141-0260 through 410-141-0266) and to request an Administrative Hearing. If the Division member requests a hearing, the Division member shall continue to be disenrolled until a hearing decision reversing that disenrollment has been sent to the Division member and the PHP:

(i) In cases where the Division member is also enrolled in the FCHP's or PCO's Medicare Advantage plan and the plan has received permission to disenroll the client, the FCHP or PCO shall provide proof of the CMS approval to disenroll the client and the date of disenrollment shall be the date approved by CMS;

(ii) The disenrollment date is 30 days after the date of approval, except as provided in subsections (iii) and (iv) of this section:

(I) The PHP Coordinator shall determine when enrollment in another PHP or with a PCM is appropriate. If appropriate, the PHP Coordinator shall contact the Division member's Department caseworker to arrange enrollment. The Division may require the Division member and/or the benefit group to obtain services from FFS Providers or a PCM until such time as they can be enrolled in another PHP;

(II) When the disenrollment date has been determined, HMU shall send a letter to the Division member with a copy to the Division member's Department caseworker and the PHP. The letter shall inform the Division member of the requirement to be enrolled in another PHP, if applicable.

(iii) If the PHP Coordinator approves a PHP's request for disenrollment because of the Division member's uncooperative or disruptive behavior, including threats or acts of

physical violence directed at a medical Provider, the Provider's staff, or other patients, or because the Division member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following additional procedures shall apply:

(I) The Division member shall be disenrolled as of the date of the PHP's request for disenrollment;

(II) All Division members in the Division member's benefit group, as defined in OAR 461-110-0720, may be disenrolled if the PHP requests;

(III) At the time of enrollment into another PHP, the Division shall notify the new PHP that the Division member and/or benefit group were previously disenrolled from another PHP at that PHP's request.

(iv) If a Division member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the PHP's PHP Coordinator. A Division member may not be disenrolled from the same PHP for a period of more than 12 months. If the Division member is reenrolled after the 12-month period and is again disenrolled for cause, the disenrollment shall be reviewed by the Department for further action.

(b) Other reasons for the PHP's requests for disenrollment include the following:

(A) If the Division member is enrolled in the FCHP or MHO on the same day the Division member is admitted to the hospital, the FCHP or MHO shall be responsible for said hospitalization. If the Division member is enrolled after the first day of the inpatient stay, the Division member shall be disenrolled, and the date of enrollment shall be the next available enrollment date following discharge from inpatient hospital services;

(B) The Division member has surgery scheduled at the time their enrollment is effective with the PHP, the Provider is not on the PHP's Provider panel, and the Division 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 PHP;

(D) The Division member had End Stage Renal Disease at the time of enrollment in the PHP;

(E) Excluding the DCO, the PHP determines that the Division member has a third party insurer. If after contacting The Health Insurance Group, the disenrollment is not effective the following month, the PHP may contact HMU to request disenrollment;

(F) If a PHP has knowledge of a Division member's change of address, the PHP shall notify the Department. The Department shall verify the address information and disenroll the Division member from the PHP, if the Division member no longer resides in

the PHP's Service Area. Division members shall be disenrolled if out of the PHP's Service Area for more than three (3) months, unless previously arranged with the PHP. 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 PHP;

(G) The Division 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 Division 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 PHP is responsible for identifying the Division members and providing sufficient proof of incarceration to HMU for review of the disenrollment request. The Division shall approve requests for disenrollment from PHPs for Division members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHPs are responsible for inpatient services only during the time a Division member was an inmate;

(H) The Division member is in a state psychiatric institution.

(4) The Division Initiated disenrollments:

(a) The Division may initiate and disenroll Division members as follows:

(A) If the Division determines that the Division member has sufficient third party resources such that health care and services may be cost effectively provided on a FFS basis, the Division may disenroll the Division member. The effective date of disenrollment shall be the end of the month in which the Division makes such a determination. The Division may specify a retroactive effective date of disenrollment if the Division member's third party coverage is through the PHP, or in other situations agreed to by the PHP and the Division;

(B) If the Division member moves out of the PHP's Service Area(s), 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 PHP;

(C) If the Division member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project or Children's Health Insurance Program, the effective date of disenrollment shall be the date specified by the Division;

(D) If the Division member dies, the effective date of disenrollment shall be through the date of death;

(E) When a non-Medicare contracting PHP is assumed by another PHP that is a Medicare Advantage plan, Division members with Medicare shall be disenrolled from the existing PHP. The effective date of disenrollment shall be the day prior to the month the new PHP assumes the existing PHP;

(F) If the Division determines that the PHP's Division member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP the effective date of the disenrollment shall be the Division member's effective date of coverage with FHIAP.

(b) Unless specified otherwise in these rules or in the Division notification of disenrollment to the PHP, all disenrollments are effective the end of the month after the request for disenrollment is approved by the Division;

(c) The Division shall inform the Division members of the disenrollment decision in writing, including the right to request an Administrative Hearing. OHP clients may request a Division hearing if they dispute a disenrollment decision by the Division;

(d) If the OHP client requests a hearing, the OHP client shall continue to be disenrolled until a hearing decision reversing that disenrollment is sent the OHP client.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-3080

Disenrollment from Coordinated Care Organizations

(1) At the time of recertification, a member may disenroll from one CCO or DCO in a service area and enroll in another CCO or DCO in that service area. The primary person in the household shall make this decision on behalf of all household members.

(2) A member who moves from one service area to another service area shall disenroll from the CCO or DCO in the previous service area and enroll with a CCO or DCO in the new service area. The member must change their address with the Authority or Department within ten days of moving.

(3) A member who is an exempt client receiving services from a non-integrated CCO shall disenroll and receive services from an integrated CCO in their service area.

(4) A member who voluntarily enrolls in a CCO or DCO per OAR 410-141-3060(19) may disenroll from their CCOs or DCO's at any time and receive health care services on a fee-for service basis or enroll in another CCO or DCO in their service area. This only applies to:

(a) Members who are eligible for both Medicare and Medicaid,

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

(c) Notwithstanding other sections of this rule, members may request disenrollment for just cause at any time pursuant to state law or CFR 438.56. This includes:

(A) The CCO or DCO does not cover the service the member seeks because of moral or religious objections;

(B) 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

(C) The member is experiencing poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

(5) The Authority may approve the disenrollment after medical review using the following just-cause considerations:

(a) Required enrollment would pose a serious health risk; and

(b) The Authority finds no reasonable alternatives.

(6) In accordance with 42 CFR 438.56, the Authority, CCO and DCO shall honor a member or Representative request for disenrollment for the following:~~The following applies to time lines for clients to change their CCO or DCO assignment:~~

(a) Without cause:

(ia) Newly eligible clients may change their CCO or DCO assignment within 90 days following the date of initial enrollment of their application for health services. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment.;

(ii) At least once every 12 months:

(iiib) Existing members may change their CCO or DCO assignment within 30 days of the Authority's automatic assignment or re-enrollment in a CCO or DCO; or

(ive) Effective retroactively on or after September 1, 2011 and in accordance with SB 201, mMembers may disenroll from may change their the CCO or DCO during their redetermination (enrollment period), or one additional time during their enrollment period based on the members choice and with Authority approval. The disenrollment shall be considered "recipient choice." assignment upon eligibility redetermination.

~~(d) Members may change enrollment in their CCO or DCO once during each enrollment period.~~

(7) Pursuant to CFR 438.56, the CCO or DCO shall not request and the Authority shall not approve disenrollment of a member due to:

- (a) A physical or behavioral disability or condition;
- (b) An adverse change in the member's health;
- (c) The member's utilization of services, either excessive or lacking;
- (d) The member's decisions regarding medical care with which the CCO or DCO disagrees;

(e) The member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, resulting from the member's special needs, except when continued enrollment in the CCO or DCO seriously impairs the CCO's or DCO's ability to furnish services to this particular member or other members.

(8) A CCO or DCO may request the Authority to disenroll a member if the CCO or DCO determines:

(a) Except as provided in OAR 410-141-3050, the member has major medical coverage, including employer sponsored insurance (ESI);

(b) The CCO or DCO determines:

(A) The member has moved to a service area the CCO or DCO does not serve;

(B) The member is out of the CCO's or DCO's area for three months without making arrangements with the CCO or DCO;

(C) The member did not initiate enrollment in the CCO or DCO serving the member's area; and

(D) The member is not in temporary placement or receiving out-of-area services.

(c) The member is in a state psychiatric institution;

(d) The CCO or DCO has verifiable information that the member has moved to another Medicaid jurisdiction; or

(e) The member is deceased.

(9) Before requesting disenrollment under the exception in section (7)(e) of this rule, a CCO or DCO must take meaningful steps to address the member's behavior, including but not limited to:

(a) Contacting the member either orally or in writing to explain and attempt to resolve the issue. The CCO or DCO must document all oral conversations in writing and send a written summary to the member. This contact may include communication from

advocates, including peer wellness specialists, where appropriate, personal health navigators and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(b) Developing and implementing a care plan in coordination with the member and the member's care team that details the problem and how the CCO or DCO shall address it;

(c) Reasonably modifying practices and procedures as appropriate to accommodate the member's circumstances;

(d) Assessing the member's behavior to determine if it results from the member's special needs or a disability;

(e) Providing education, counseling and other interventions to resolve the issue; and

(f) Submitting a complete summary to the Authority if the CCO or DCO requests disenrollment.

(10) The Authority may disenroll members of CCOs or DCOs for the reasons specified in Section (8) without receiving a disenrollment request from a CCO or DCO.

(11) The CCO or DCO shall request the Authority to suspend a member's enrollment when the inmate is incarcerated in a State or Federal prison, a jail, detention facility or other penal institution for no longer than 12 months. The CCO or DCO shall request that the Authority disenroll a member when the inmate is incarcerated in a State or Federal prison, jail, detention facility or other institution for longer than 12 months. This does not include members on probation, house arrest, living voluntarily in a facility after adjudication of their case, infants living with inmates or inmates admitted for inpatient hospitalization. The CCO or DCO is responsible for identifying the members and providing sufficient proof of incarceration to the Authority for review of the request for suspension of enrollment or disenrollment. CCOs shall pay for inpatient services only during the time a member is an inmate and enrollment is otherwise suspended.

(12) Unless otherwise specified in these rules or in the Authority notification of disenrollment to the CCO or DCO, all disenrollments are effective at the end of the month the Authority approves the disenrollment, with the following exceptions;

(a) The Authority may specify a retroactive disenrollment effective date if the member:

(A) Has third party coverage including employee-sponsored insurance. The effective date shall be the date the coverage begins;

(B) Enrolls in a program for all-inclusive care for the elderly (PACE). The effective date shall be the day before PACE enrollment;

(C) Is admitted to the State Hospital. The effective date shall be the day before hospital admission; or

(D) Becomes deceased. The effective date shall be the date of death.

(b) The Authority may retroactively disenroll or suspend enrollment if the member is incarcerated pursuant to section (11) of this rule. The effective date shall be the date of the notice of incarceration or the day before incarceration, whichever is earlier.

(c) The Authority shall specify a disenrollment effective date if the member moves out of the CCO's or DCO's service area. The Authority shall recoup the balance of that month's capitation payment from the CCO or DCO;

(d) The Authority may specify the disenrollment effective date if the member is no longer eligible for OHP.

(13) The Authority shall inform the members of a disenrollment decision in writing, including the right to request a contested case hearing to dispute the Authority's disenrollment if the Authority disenrolled the member for cause that the member did not request. If the member requests a hearing, the disenrollment shall remain in effect pending outcome of the contested case hearing.

(14) For purposes of a member's right to a contested case hearing, "disenrollment" does not include the Authority's:

(a) Transfer of a member from a PHP to a CCO or DCO;

(b) Transfer of a member from a CCO or DCO to another CCO or DCO; or

(c) Automatic enrollment of a member in a CCO or DCO.

(15) The Authority may approve the transfer of 500 or more members from one CCO or DCO to another CCO or DCO if:

(a) The members' provider has contracted with the receiving CCO or DCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO or DCO; and

(b) Members are offered the choice of remaining enrolled in the transferring CCO or DCO.

(16) Members may not be transferred under section (15) until the Authority has evaluated the receiving CCO or DCO and determined that the CCO or DCO meets criteria established by the Authority by rule, including but not limited to ensuring that the CCO or DCO maintains a network of providers sufficient in numbers and areas of

practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(17) The Authority shall provide notice of a transfer under section (15) to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(18) Except as otherwise allowed by rule, a member may transfer from one CCO or DCO to another CCO or DCO no more than once during each enrollment period.

Stat. Auth.: ORS 413.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 - 414.685