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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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RULE CAPTION

Amendment to Program Updates: Marketing, Benefits, Assessment Plan, Measures and Enrollment

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

410-141-0000, 410-141-0050, 410-141-0120, 410-141-0180, 410-141-0270, 410-141-0410, 410-141-0420, 410-141-0480, 410-141-0740, 410-141-3010, 410-141-3015, 410-141-3050, 410-141-3120, 410-141-3145, 410-141-3200, 410-141-3270

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 414.042, 414.625, 414.635, 414.651

Other Auth.:

Stats. Implemented: ORS 414.610

RULE SUMMARY

The OHP program administrative rules govern the Division of Medical Assistance Programs' payments for services provided to clients. The Division needs to permanently amend these rules to incorporate program updates, federal and state regulations, and housekeeping changes.

Rhonda Busek Rhonda Busek 7-9-14
Authorized Signer Printed Name Date

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410-141-0000

Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply:

(1) “Action” means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(a) The denial or limited authorization of a requested service including the type or level of service;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial in whole or in part of payment for a service;

(d) The failure to provide services in a timely manner as defined by the Division of Medical Assistance Programs (Division);

(e) The failure of a PHP or CCO to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:

(A) From any other provider (in terms of training, experience, and specialization) not available within the network;

(B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.

(C) Because the only plan or provider available does not provide the service due to moral or religious objections;

(D) Because the member’s provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or

(E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.

(2) “Adjudication” means the act of a court or entity in authority when issuing an order, judgment, or decree; as in a final CCO or MCO claims decision or OHA issuing a final hearings

decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

(3) “Appeal” means a request for review of an action.

(4) “Behavioral Health” means mental health conditions as well as substance use disorders.

(5) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

(6) “Capitated Services” mean those covered services that a PHP or Primary Care Manager (PCM) agrees to provide for a capitation payment under contract with the Authority.

(7) “Capitation Payment” means:

(a) Monthly prepayment to a PHP for health services the PHP provides to members;

(b) Monthly prepayment to a PCM to provide primary care management services for a member enrolled with the PCM.

(8) “CCO Payment” means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.

(9) “Certificate of Authority” means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(10) “Certified or Qualified Health Care Interpreter” means a trained person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into spoken English and readily able to translate the written or oral statement of other persons into the spoken language of the person with limited English proficiency. A certified Health Care Interpreter has met Oregon training standards for certification, has received certification from a national certification body, and is listed in the Oregon Health Care Interpreter Registry; a qualified Health Care Interpreter has met Oregon training standards for qualification and has demonstrated language proficiency in English and a second language where certification is not possible using a standardized, nationally recognized language proficiency assessment and is listed in the Oregon Health Care Interpreter Registry.

(11) “Certified Traditional Health Worker” means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305.

(12) “Cold Call Marketing” means a PCP’s or CCO’s unsolicited personal contact with a potential member for the purpose of marketing.

(13) “Co-morbid Condition” means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(14) “Community Advisory Council” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.

(15) “Community Health Worker” means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(16) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority’s Addictions and Mental Health Division (AMH).

(17) “Community Standard” means typical expectations for access to the health care delivery system in the member’s community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs and to PCM members take into consideration the community standard and be adequate to meet the needs of the Division and PCM members.

(18) “Condition/Treatment Pair” means diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9-CM), the Diagnostic and Statistical Manual

of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

(19) “Contract” means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.

(20) “Converting MCO” means a CCO that:

(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;

(b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.

(21) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

(22) “Coordinated Care Services” mean a CCO’s fully integrated physical health, behavioral health services pursuant to ORS 414.725, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(23) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(24) “Covered Services” mean medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the legislature funds based on the Prioritized List of Health Services.

(25) “Declaration for Mental Health Treatment” means a written statement of an individual’s decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment which is honored when the individual is unable to make such decisions.

(26) “Dental Care Organization (DCO)” means a PHP that provides and coordinates dental services as capitated services under OHP.

(27) “Dental Case Management Services” mean services provided to ensure member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(28) “DCBS Reporting CCO” means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(29) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection agency.

(30) “Diagnostic Services” mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(31) “Disenrollment” means the act of removing a member from enrollment with a PHP, PCM, or CCO.

(32) “Enrollment” means the assignment of a member to a PHP, PCM, or CCO for management and receipt of health services.

(33) “Free-Standing Mental Health Organization (MHO)” means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.

(34) “Fully-Capitated Health Plan (FCHP)” means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.

(35) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(36) “Grievance” means a member’s complaint to a PHP, CCO, or to a participating provider about any matter other than an action.

(37) “Grievance System” means the overall system that includes:

(a) Grievances to a PHP or CCO on matters other than actions;

(b) Appeals to a PHP or CCO on actions; and

(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or state statute.

(38) “Health Services” means:

(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health that

includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;

(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

(39) “Health System Transformation (HST)” means the transformation of health care delivery in medical assistance programs as prescribed by 2011 House Bill 3650, Chapter 602, Oregon Laws 2011 and 2012 Enrolled Senate Bill 1580, Chapter 8, Oregon Laws 2012; and including the CCO Implementation Proposal from the Oregon Health Policy Board (January 24, 2012) approved by Section 2 of 2012 Enrolled Senate Bill 1580.

(40) “Holistic Care” means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.

(41) “Intensive Case Management (ICM)” means a specialized case management service provided by fully capitated health plans to members identified as aged, blind, or disabled who have complex medical needs including:

(a) Early identification of members eligible for ICM services;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(42) “Licensed Health Entity” means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(43) “Line Items” mean condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

(44) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(45) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(46) “Mental Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.

(47) “Mental Health Case Management” means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(48) “Mental Health Organization (MHO)” means a PHP that provides capitated behavioral services for clients.

(49) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(50) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

(51) “Non-Participating Provider” means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.

(52) “OHA or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.

(53) “Other Non-Medical Services,” *also referred to as flexible services*, means health-related, non-state plan services intended to improve care delivery and member health. Flexible services are health related and cost-effective alternatives to more technical services. Flexible services are unable to be reported in the conventional manner using CPT or HCPCS codes and may effectively treat or prevent the physical or mental healthcare condition documented in the member’s health or clinical record. The Authority has revised the reporting framework so that CCOs also report qualified flexible services to the Authority in a grouping called “health related services” to be accounted for in the CCO’s medical or member service expenses. These expenditures are not counted as administrative costs when determining the medical loss ratio. Flexible services may include, but are not limited to:

(a) Training and education for health improvement or management (e.g., classes on healthy meal preparation, diabetes self-management curriculum);

(b) Self-help or support group activities (e.g., post-partum depression programs, Weight Watchers groups);

(c) Care coordination, navigation, or case management activities (not covered under state plan benefits, e.g., high utilizer intervention program);

(d) Home and living environment items or improvements (non-DME items to improve mobility, access, hygiene, or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes, or other special clothing);

(e) Transportation not covered under State Plan benefits (e.g., other than transportation to a medical appointment);

(f) Programs to improve the general community health (e.g., farmers' market in the "food desert");

(g) Housing supports related to social determinates of health (e.g., shelter, utilities, or critical repairs);

(h) Assistance with food or social resources (e.g., supplemental food, referral to job training or social services);

(i) Other (describe).

(54) "Participating Provider" means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.

(55) "PCM Member" means a client enrolled with a primary case manager.

(56) "Peer Wellness Specialist" means an individual who assists behavioral health services consumers to reduce stigmas and discrimination and to provide direct services to assist individuals to create and maintain recovery, health, and wellness by:

(a) Assessing the individual's behavioral health service and support needs through community outreach;

(b) Assisting individuals with access to available services and resources; and

(c) Addressing barriers to services and providing education and information about available resources and behavioral health issues.

(57) "Person Centered Care" means care that reflects the individual patient's strengths and preferences; reflects the clinical needs of the patient as identified through an individualized assessment; is based upon the patient's goals; and will assist the patient in achieving the goals.

(58) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcomes.

(59) "Physician Care Organization (PCO)" means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.

(60) “Potential Member” means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.

(61) “Premium” means:

(a) CCO payment when the payment is made by the Authority to the CCO for purposes of OAR 410-141-3340 to 410-141-3395;

(b) Also includes any other revenue received by the CCO for the provision of healthcare services over a defined period of time.

(62) “Primary Care Management Services” means services that ensure PCM members obtain health services that are necessary to maintain physical and emotional development and health.

(63) “Primary Care Manager (PCM)” means a primary care provider who agrees to provide primary care management services to their members.

(64) “Prioritized List of Health Services” means the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.

(65) “Service Area” means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(66) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(67) “Treatment Plan” for behavioral health consists of the following three components:

(a) “Emergency Response System” means the coordinated method of triaging the mental health service needs of members and providing covered services when needed. The system operates 24-hours a day, 7-days a week and includes, but is not limited to: after hours on call staff, telephone and in person screening, outreach, and networking with hospital emergency rooms and police.

(b) “Emergency Services” means covered services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency situation.

(c) “Services Coordination” means services provided to members who require access to and receive services from one or more Allied Agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability.

(68) “Treatment Plan” for physical and dental health consists of the following two components:

(a) “Emergency Services Related to Physical Health” means services from a qualified provider necessary to evaluate or stabilize an emergency medical condition including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the member’s condition is not likely to materially deteriorate from or during a member’s discharge from a facility or transfer to another facility.

(b) “Services Coordination” means services provided to members who require access to and receive covered services or long-term care services from one or more allied agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability;

(69) “Service Authorization Request” means a member’s initial or continuing request for the provision of a service including member requests made by their provider or the member’s authorized representative.

(70) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months; and

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0050

MHO Enrollment for Children Receiving Child Welfare Services

Pursuant to and in the administration of the Authority in OAR 410-141-0060, Children, Adults and Families (CAF) or the Oregon Youth Authority (OYA) selects Prepaid Health Plans (PHPs) for a child receiving CAF Child Welfare services or OYA services with the exception of children in subsidized adoption and guardianship. This rule implements and further describes how the Oregon Health Authority (Authority) shall administer its authority under OAR 410-141-0060 and 410-141-3060 for purposes of making enrollment decisions and OAR 410-141-0080 and 410-141-3080 for purposes of making disenrollment decisions for children receiving CAF Child Welfare services or OYA services;

(1) The Authority has determined that, to the maximum extent possible, all children receiving CAF services should be enrolled in Mental Health Organizations (MHOs) or Coordinated Care Organizations (CCO) at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment from a MHO or CCO is authorized by the Authority in accordance with this section and OAR 410-141-0080 and 410-141-3080:

(a) Notwithstanding OAR 410-141-0060(4)(a) or 410-141-3060 or 410-141-0080(2)(b)(E) or 410-141-3080, children receiving CAF services are not exempt from mandatory enrollment in an MHO or CCO on the basis of third party resources (TPR) mental health services coverage;

(b) A decision to use fee-for-service (FFS) open card for a child receiving CAF services should be reviewed by the Authority if the child's circumstances change and at the time of redetermination to consider whether the child should be enrolled in a MHO or CCO.

(2) When a child receiving CAF services is being transferred from one MHO to another or one CCO to another or for children transferring from FFS to a MHO or CCO, the MHO or CCO shall facilitate coordination of care consistent with OAR 410-141-0160 or 410-141-3160:

(a) MHOs and CCOs shall work closely with the Authority to ensure continuous MHO or CCO enrollment for children receiving CAF services;

(b) If the Authority determines that disenrollment should occur, the MHO or CCO shall continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible MHO or CCO.

(3) It is not unusual for a child receiving CAF services to experience a change of placement that may be permanent or temporary in nature. Consistent with OAR 410-141-0080 or 410-141-3080, the Authority will verify the address change information to determine whether a child receiving CAF services no longer resides in the MHO's or CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the MHO's or CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to a placement in the MHO's or CCO's service area at the end of the temporary placement;

(b) Unless a corresponding change in MHO capitation rates is implemented, a child receiving CAF services placed in behavioral rehabilitation services (BRS) settings shall be enrolled in the MHO or CCO that serves the region in which the BRS setting is located, unless an out of area exception is requested by the MHO or CCO and agreed to by the Authority for purposes related to continuity of care.

(4) If the child receiving CAF services is enrolled in a MHO or CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the MHO or CCO shall be responsible for covered services during that placement even if the location of the facility is outside of the MHO's or CCO service area:

(a) The child receiving CAF services is presumed to continue to be enrolled in the MHO or CCO with which the child was most recently enrolled. An admission to a PRTS facility shall be deemed a temporary placement for purposes of MHO or CCO enrollment. Any address change or Authority system identifier (e.g., C5 status) change associated with the placement in the PRTS facility does not constitute a change of residence for purposes of MHO or CCO enrollment and shall not constitute a basis for disenrollment from the MHO or CCO, notwithstanding OAR 410-141-0080 and 410-141-3080. If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate MHO or CCO and assign an enrollment date that provides for continuous MHO or CCO coverage with the appropriate MHO or CCO. If the child had been enrolled in a different MHO or CCO in error, the Authority shall disenroll the child from that MHO or CCO and recoup the capitation payments;

(b) Immediately upon discharge from long-term psychiatric care and prior to admission to a PRTS, a child receiving CAF services should be enrolled in an MHO or CCO. At least two weeks prior to discharge of a child receiving CAF services from a long-term psychiatric care (SAIP, SCIP, or STS) facility to a PRTS facility, the long-term care facility shall consult with the Authority about which MHO or CCO will be assigned in order to provide for enrollment in the MHO or CCO and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge from long-term psychiatric care.

(5) Notwithstanding OAR 410-141-0060(6) and (7), 410-141-3060, 410-141-0080, and 410-141-3080, if a child receiving CAF services is enrolled in a MHO or CCO after the first day of an admission to PRTS, the date of enrollment shall be effective the next available enrollment date following discharge from PRTS to the MHO or CCO assigned by the Authority:

(a) For purposes of these rules and to assure continuity of care for the child upon discharge, the next available enrollment date shall mean immediately upon discharge;

(b) At least two weeks prior to discharge, the PRTS facility shall consult with the Authority about which MHO or CCO will be assigned and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-141-0120

Managed Care Prepaid Health Plan (PHP) Provision of Health Care Services

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and ancillary services, and in those

categories of services included in contract or agreements with the Division of Medical Assistance Programs (Division) and Addictions and Mental Health (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all participating providers providing covered services to Division members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination based on the requirements of the discipline or profession that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges, and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities including oversight of the following processes:

(A) PHPs shall ensure that covered services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services and that participating providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, Oregon Health Plan (OHP) administrative rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and shall provide accurate and timely information about license or certification expiration and renewal dates to the Division. PHPs may not refer Division members to or use providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or certification is expired or not renewed or is subject to licensing or certification sanction, the PHP shall immediately notify the member's Provider Services Unit.

(D) PHPs may not refer members to or use providers who have been terminated from the Division or excluded as Medicare and Medicaid providers by Centers for Medicare and Medicaid (CMS) or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs may not accept billings for services to members provided after the date of such provider's exclusion, conviction, or termination. The Oregon Health Authority (Authority) has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they shall

submit to their Coordinated Care Account Representative (CAR) for Authority approval prior to use. PHPs shall obtain information required on the appropriate disclosure form from individual practitioners and entities and shall retain the disclosure statements in the PHP credential files. If a PHP knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of “nolo contendere”), the PHP shall immediately notify the Division’s Provider Services Unit.

(E) PHPs shall obtain and use the Division’s provider enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number “999999” may no longer be used in encounter data reporting or provider capacity reporting. PHPs shall require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).

(F) The provider enrollment request (for encounter purposes) and disclosure statement described in paragraphs (D) and (E) require the disclosure of taxpayer identification numbers. The taxpayer identification number will be used for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, administration of tax laws, and may be used to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and the Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification number(s) may result in denial of enrollment as a provider, denial of a provider number for encounter purposes, denial of continued enrollment as a provider, and deactivation of all provider numbers used by the provider for encounters.

(b) FCHPs, Physician Care Organization (PCOs), and Dental Care Organizations (DCOs) shall have written procedures that provide newly enrolled members with information about which participating providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, and DCOs shall have written procedures that allow and encourage a choice of a Primary Care Provider (PCP) or clinic for physical health and dental health services by each member. These procedures shall enable a member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that member;

(d) If the member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO shall ensure the member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign members to PCPs or clinics shall document the unsuccessful efforts to elicit the member’s choice before assigning a member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30

calendar days after enrollment shall notify the member of the assignment and allow the member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to the member's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) The following services may be received by Division members from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), the member is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve

publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and planning committees;

(e) FCHPs and PCOs shall report to the Division on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled member receives timely, adequate, and appropriate health care services necessary to establish and maintain the health of the member. An FCHP's liability covers the period between the member's enrollment and disenrollment with the FCHP, unless the member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the member's PCP or designated practitioner determines the care is no longer medically appropriate.

(4) A PCO's liability covers the period between the member's enrollment and disenrollment with the PCO, unless the member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of the Division.

(5) The member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services and shall coordinate benefits for shared members to ensure that the member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible member is enrolled in a FCHP or PCO with a Medicare HMO component, the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health or dental care for that member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer members to the divisions of the Authority and local and regional allied agencies that may offer services not covered under the capitation payment;

(c) FCHPs and PCOs may not require members to obtain the approval of a PCP in order to gain access to mental health and Substance Use Disorder assessment and evaluation services. Division members may refer themselves to MHO services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 192.518 - 192.526, 556.320, 414.065, 414.727, and 441.223

410-141-0180

Oregon Health Plan Prepaid Health Plan Record Keeping

(1) Maintenance and Security: Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete clinical records that document the care received by the members from the PHP's primary care and referral providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's participating providers shall have written policies and procedures to ensure that clinical records related to the member's individual identifiable health information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50, and section (3) of this rule. If the PHP is a public body within the meaning of the Oregon public records law, the policies and procedures shall ensure that member privacy is maintained in accordance with 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their participating providers may not release or disclose any information concerning a member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the member;

(b) Except in an emergency, PHPs' participating providers shall obtain a written authorization for release of information from the member or the legal guardian or the member's legal Power of Attorney for Health Care Decisions before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information and shall be placed in the member's record. In an emergency, release of service information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the member;

(c) PHPs may consider a member age 14 or older competent to authorize or prevent disclosure of mental health and substance use disorder treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the member's clinical treatment requirements.

(3) Exchange of Protected Health Information for Treatment Purposes without Authorization: In accordance with ORS 192.518 to 192.526 and with required acknowledgement, the Authority and PHP's may share the following protected health information without member authorization for the purpose of treatment activities. The protected health information that may be disclosed, commonly found in claims or encounters, includes the following:

- (a) Oregon Health Plan member name;
- (b) Medicaid recipient number;
- (c) Performing provider number;
- (d) Hospital provider name and attending physician name;
- (e) Diagnosis;
- (f) Dates of service;
- (g) Procedure code;
- (h) Revenue code;
- (i) Quantity of units of service provided;
- (j) Medication prescription and monitoring;

(4) Access to clinical records:

(a) Provider access to clinical records:

(A) PHPs shall release health service information requested by a provider involved in the member's care within ten working days of receiving a signed authorization for release of information;

(B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service providers, have access to the applicable contents of a member's mental health record when necessary for use in the member's diagnosis or treatment. Such access is permitted under ORS 179.505(6);

(b) Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' participating providers shall upon request, provide the member access to their own clinical

record, allow for the record to be amended or corrected, and provide copies within ten working days of the request. PHPs' participating providers may charge the member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' participating providers shall upon receipt of a member's written authorization for release of information, provide access to the member's clinical record. PHPs' participating providers may charge for reasonable duplication costs;

(d) Authority Access to Records: PHPs shall cooperate with the Division, the Addictions and Mental Health Division (AMH), the Medicaid Fraud Unit, and AMH representatives for the purposes of audits, inspection, and examination of members' clinical and administrative records.

(5) Retention of Records: All clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records shall be retained until all issues arising out of the action are resolved.

(6) Requirements for Clinical Records: PHPs shall have policies and procedures that ensure maintenance of a clinical record keeping system that is consistent with state and federal regulations to which the PHP is subject. The system shall assure accessibility, uniformity, and completeness of clinical information that fully documents the member's condition and the covered and non-covered services received from PHPs' participating or referred providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PHPs shall document all monitoring and corrective action activities:

(a) A clinical record shall be maintained for each member receiving services that documents all types of care needed or delivered in all settings whether services are delivered during or after normal clinic hours;

(b) All entries in the clinical record shall be signed and dated;

(c) Errors to the clinical record shall be corrected as follows:

(A) Incorrect data shall be crossed through with a single line;

(B) Correct and legible data shall be added followed by the date corrected and initials of the individual making the correction;

(C) Removal or obliteration of errors shall be prohibited;

(d) The clinical record shall reflect a signed and dated authorization for treatment for the member, his or her legal guardian, or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's or clinic's clinical record shall include data that forms the basis of the diagnostic impression of the member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's member's clinical record receiving services shall include the following information as applicable:

(A) Member name, date of birth, sex, address, telephone number, and identifying number as applicable;

(B) Name, address, and telephone number of next of kin, legal guardian, Power of Attorney for Health Care Decisions, or other responsible party;

(C) Medical, dental, or psychosocial history as appropriate;

(D) Dates of service;

(E) Names and titles of individuals performing the services;

(F) Physicians' orders;

(G) Pertinent findings on examination and diagnosis;

(H) Description of medical services provided including medications administered or prescribed; tests ordered or performed, and results;

(I) Goods or supplies dispensed or prescribed;

(J) Description of treatment given and progress made;

(K) Recommendations for additional treatments or consultations;

(L) Evidence of referrals and results of referrals;

(M) Copies of the following documents if applicable:

(i) Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations, or evaluations;

(ii) Plans of care including evidence that the member was jointly involved in the development of the mental health treatment plan;

(iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;

(iv) Emergency department and screening services reports;

- (v) Consultation reports;
- (vi) Medical education and medical social services provided;
- (N) Copies of signed authorizations for release of information forms;
- (O) Copies of medical and mental health directives;
- (f) Based on written policies and procedures, the clinical record keeping system developed and maintained by PHPs' participating providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;
- (g) The PCP or clinic shall have policies and procedures that accommodate members requesting to review and correct or amend their clinical record;
- (h) PHPs' shall maintain other records in either the clinical record or within the PHP's administrative offices. Other records shall include the following:
 - (A) Names and phone numbers of the member's prepaid health plans, primary care physician or clinic, primary dentist, and mental health Practitioner, if any in the MHO records;
 - (B) Copies of Client Process Monitoring System (CPMS) *also known as* Measures and Outcomes Tracking System (MOTS) enrollment forms in the MHO's records;
 - (C) Copies of long-term psychiatric care determination request forms in the MHO's records;
 - (D) Evidence that the member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;
 - (E) Evidence that the member has been informed of his or her rights and responsibilities in the MHO records;
 - (F) ENCC records in the FCHP's or PCO's records;
 - (G) Complaint and Appeal records; and
 - (H) Disenrollment requests for cause and the supporting documentation.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.651

410-141-0270

Prepaid Health Plan Marketing Requirements for Potential Members

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

(a) “Cold-call Marketing” means any *unsolicited personal contact* with a potential member for the purpose of marketing by the PHP; Cold-call marketing methodologies may include, but are not limited to, door to door, telephone, mail, or e-mail.

(b) “Marketing” means any communication from a PHP to a potential member who is not enrolled in the PHP that can reasonably *be interpreted as intended to compel or entice* the potential members to enroll in that particular PHP;

(c) “Marketing Materials” means materials that are produced in any medium by or on behalf of a PHP and that can reasonably *be interpreted as intended to market* to potential members;

(d) “Outreach” means any communication from a PHP to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP. Outreach activities include, but are not limited to, the act of *raising the awareness of the PHP, the PHP’s subcontractors and partners, the PHP contractually required programs and services, and the promotion of healthful behaviors, health education, and health related events.*

(e) “Outreach Materials” means materials that are produced in any medium, by or on behalf of a PHP that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP.

(f) “Potential Member” means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has *not yet enrolled with a specific PHP.*

(2) PHPs must comply with the information required in 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the PHP provides accurate oral and written information a potential member needs to make an informed decision on whether to enroll in that PHP. In so doing, the PHP must:

(a) Not distribute any marketing materials without first obtaining state approval;

(b) Distribute the materials to its entire service area as indicated in its PHP contract;

(c) Not seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance;

(d) Not directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The creation of name recognition shall not constitute an attempt by the PHP to compel or entice a client’s enrollment and are expressly permitted. Communication methodologies may

include, but are not limited to: brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(4) PHPs' or their subcontractor's communications that express participation in or support for a PHP by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(5) PHPs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA will confirm information before posting.

(6) PHPs have sole accountability for producing or distributing materials following OHA approval.

(7) PHPs shall comply with the Authority marketing materials submission guidelines. PHPs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

- (a) A list of communication or outreach materials subject to review by the Authority;
- (b) A clear explanation of the Authority's process for review and approval of marketing materials;
- (c) A process for appeals of the Authority's edits or denials;
- (d) A marketing materials submission form to ensure compliance with PHP marketing rules; and
- (e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0410

Oregon Health Plan Primary Care Managers

(1) Primary Care Managers (PCM) provide Primary Care Management Services under the Oregon Health Plan. PCMs provide Primary Care Management Services as defined in OAR 410-141-0000 PCM Services:

- (a) Preventive services, primary care services, and specialty services including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics, and tribal health clinics;

(b) Inpatient hospital services; and

(c) Outpatient hospital services except laboratory, x-ray, and maternity management services.

(2) Services that are not PCM Case Managed Services include, but are not limited to, the following:

(a) Anesthesiology services;

(b) Dental care services;

(c) Durable medical equipment;

(d) Family Planning Services;

(e) Immunizations, treatment for communicable diseases, and treatment for sexually transmitted diseases provided by a publicly funded clinic;

(f) Laboratory services;

(g) Maternity case management services;

(h) Medical transportation services;

(i) Mental health and Substance Use Disorder treatment (SUD) services;

(j) Pharmacy services;

(k) Physical therapy, occupational therapy, speech therapy, and audiology services;

(l) Preventive services for acquired immune deficiency syndrome and human immune-deficiency virus;

(m) Routine eye examinations and dispensing of vision materials;

(n) School-based services provided under an individual education plan or an individual family service plan;

(o) Targeted case management services; and

(p) Diagnostic imaging.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

410-141-0420

Managed Care Prepaid Health Plan Billing and Payment under the Oregon Health Plan

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please see OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) Providers shall submit all billings for OHP members to Prepaid Health Plans (PHPs) and the Division within four months of the date of service, subject to other applicable Division billing rules. A billing submitted within four months of the date of service that was denied may be resubmitted within six months of the date of service. Providers shall submit billings to PHPs within the four-month time frame except in the following cases in which providers shall submit billings to PHPs within 12 months of the date of service:

(a) Pregnancy;

(b) Eligibility issues such as retroactive deletions or retroactive enrollments;

(c) Medicare is the primary payer;

(d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of provider to certify the Division member's eligibility); or

(e) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payer of last resort and is not considered an alternative liability or TPL.

(2) Providers shall be enrolled with the Division to be eligible for Division fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Addictions and Mental Health (AMH) Division before enrollment with the Division or to be eligible for PHP payment for services. Providers may be retroactively enrolled in accordance with OAR 410-120-1260 (Provider Enrollment).

(3) Providers, including mental health providers, shall be enrolled with the Division either as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the servicing provider is not excluded per federal and state standard as defined in OAR 407-120-0300.

(4) Providers shall verify before rendering services that the member is eligible for the Division of Medical Assistance Programs on the date of service using the Division tools and the PHP's tools, as applicable, and that the service to be rendered is covered under the OHP Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before rendering services. Before providing a non-covered service, the provider shall complete and have the member sign a Division 3165, or facsimile, as described in OAR 410-120-1280.

(5) PHPs shall pay for all capitated services. These services shall be billed directly to the PHP, unless the PHP or the Division specifies otherwise. PHPs may require providers to obtain preauthorization to deliver certain capitated services.

(6) Payment by the PHP to participating providers for capitated services is a matter between the PHP and the participating provider except as follows:

(a) Preauthorizations:

(A) PHPs shall have written procedures for processing preauthorization requests received from any provider. The procedures shall specify time frames for:

(i) Date stamping preauthorization requests when received;

(ii) Determining within a specific number of days from receipt whether a preauthorization request is valid or non-valid;

(iii) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;

(iv) The specific number of days following receipt of the additional information that a redetermination shall be made;

(v) Providing services after office hours and on weekends that require preauthorization;

(vi) Sending notice of the decision with appeal rights to the member when the determination is made to deny the requested service as specified in OAR 410-141-0263.

(B) PHPs shall make a determination on at least 95 percent of valid preauthorization requests within two working days of receipt of a preauthorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility. Preauthorization for prescription drugs shall be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the PHP shall provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHPs shall notify providers of such determination within two working days of receipt of the request;

(C) For expedited preauthorization requests in which the provider indicates or the PHP determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(i) The PHP shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service;

(ii) The PHP may extend the three working days-time period by up to 14 calendar days if the member requests an extension or if the PHP justifies to the Division a need for additional information and how the extension is in the member's interest.

(D) For all other preauthorization requests, PHPs shall notify providers of an approval, denial, or need for further information within 14 calendar days of receipt of the request. PHPs shall make reasonable efforts to obtain the necessary information during the 14 day period. However, the PHP may use an additional 14 days to obtain follow-up information if the PHP justifies (to the Division upon request) the need for additional information and how the delay is in the member's interest. If the PHP extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 410-141-0263. The PHP shall make a determination as the member's health condition requires but no later than the expiration of the extension.

(b) Claims payment:

(A) PHPs shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for:

(i) Date stamping claims when received;

(ii) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(iii) The specific number of days allowed for follow up of pended claims to obtain additional information;

(iv) The specific number of days following receipt of additional information that a determination shall be made; and

(v) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim.

(B) PHPs shall pay or deny at least 90 percent of valid claims within 45 calendar days of receipt and at least 99 percent of valid claims within 60 calendar days of receipt. PHPs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

(C) PHPs shall provide written notification of PHP determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-0263.

(D) PHPs may not require providers to delay billing to the PHP;

(E) PHPs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare and may not require non-Medicare approved providers to bill Medicare;

(F) PHPs shall not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(G) PHPs may not delay or deny payments because a co-payment was not collected at the time of service.

(c) FCHPs, PCOs, and MHOs shall pay for Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the member receives within the PHP for

authorized referral care and for urgent care services or emergency services the member receives from non-participating providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers;

(d) FCHPs and PCOs shall pay transportation, meals, and lodging costs for the member and any required attendant for out-of-state services (that the FCHP and PCO has arranged and authorized when those services are available within the state, unless otherwise approved by the Division);

(e) PHPs shall pay for covered services provided by a non-participating provider that were not preauthorized if the following conditions exist:

(A) It can be verified that the participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(B) The covered service was delivered in good faith without the preauthorization; and

(C) It was a covered service that would have been preauthorized with a participating provider if the PHP's referral protocols had been followed;

(D) The PHP shall make payment to non-participating providers (providers enrolled with the Division that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.

(7) Other services:

(a) Members enrolled with PHPs may receive certain services on a Division FFS basis. These services are referred to as non-capitated services;

(b) Certain services shall be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Division on a Division FFS basis. Before providing services, providers should verify a member's eligibility via the web portal or AVR. For some mental health services, providers will need to contact the CMHP directly. In addition, the provider may call the PHP to obtain information about coverage for a particular service or preauthorization requirements;

(c) Services authorized by the PHP or CMHP are subject to the rules and limitations of the appropriate Division administrative rules and supplemental information including rates and billing instructions;

(d) Providers shall bill the Division directly for non-capitated services in accordance with billing instructions contained in the Division administrative rules and supplemental information;

(e) The Division shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions, and Division administrative rules and supplemental information;

(f) The Division may not pay a provider for provision of services for which a PHP has received a capitation payment unless otherwise provided for in OAR 410-141-0120;

(g) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Division, AMH, or PHP except as provided for in Division administrative rules and supplemental information (e.g., capitated services that are not included in the nursing facility all-inclusive rate); and

(h) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the FCHP or PCO would make for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(8) Coverage of services through the OHP Benefit Package of covered services is limited by OAR 410-141-0500 (Excluded Services and Limitations for OHP Clients).

(9) OHP clients enrolled with a PCM receive services on a FFS basis:

(a) PCMs are paid a per client-per month payment to provide PCM Services in accordance with OAR 410-141-0410, PCM Medical Management;

(b) PCMs provide primary care access and management services for preventive services, primary care services, referrals for specialty services, limited inpatient hospital services, and outpatient hospital services. The Division payment for these PCM managed services is contingent upon PCM authorization;

(c) All PCM managed services are covered services that shall be billed directly to the Division in accordance with billing instructions contained in the Division administrative rules and supplemental information;

(d) The Division shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

(10) All OHP members enrolled with a PCO receive inpatient hospital services on a FFS basis:

(a) May receive services directly from any appropriately enrolled provider;

(b) All services shall be billed directly to the Division in accordance with FFS billing instructions contained in the Division administrative rules and supplemental information;

(c) The Division shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

(11) OHP clients not enrolled with a PHP receive services on a FFS basis:

- (a) Services may be received directly from any appropriate enrolled provider;
- (b) All services shall be billed directly to the Division in accordance with billing instructions contained in the Division administrative rules and supplemental information;
- (c) The Division shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-141-0480

Oregon Health Plan Benefit Package of Covered Services

- (1) Division members are eligible to receive, subject to section (11) of this rule, those treatments for the condition/treatment pairs funded on the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are medically or dentally appropriate, except that services shall also meet the prudent layperson standard defined in OAR 410-141-0140. Refer to 410-141-0520 for funded line coverage information.
- (2) Medical Assistance Benefit Packages follow practice guidelines adopted by the HERC in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.
- (3) Diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services regardless of the placement of the condition on the Prioritized List of Health Services.
- (4) Comfort care is a covered service for a member with a terminal illness.
- (5) Preventive services promoting health and reducing the risk of disease or illness are covered services for members. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors (See OAR 410-141-0520 Prioritized List of Health Services).
- (6) Ancillary services are covered subject to the service limitations of the OHP program rules when the services are medically or dentally appropriate for the treatment of a covered condition/treatment pair, or the provision of ancillary services will enable the member to retain or attain the capability for independence or self-care.
- (7) The provision of SUD services shall comply with Addictions and Mental Health Division (AMH) administrative rules, OAR 415-012-0000 "Standards for Approval/Licensure of Alcohol and Other Drug Abuse Programs," OAR 415-020 "Standards for Outpatient Synthetic Opiate

Treatment Programs,” OAR 415-050 “Standards for Alcohol Detoxification Centers,” OAR 309-018 “Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services,” OAR 309-019 “Outpatient Addictions and Mental Health Services,” OAR 309-022 “Intensive Treatment Services for Children and Adolescents and Children’s Emergency Safety Intervention Specialist,” and the requirements in the SUD subsection of the Statement of Work in the CCO, FCHP, and PCO contracts.

(8) In addition to the coverage available under section (1) of this rule, a member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:

(a) Services may be provided if it can be shown that:

(A) The OHP member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;

(D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded co-morbid conditions or disabilities shall be represented by an ICD-9-CM diagnosis code or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there shall be a medical determination and finding by the Division for fee-for-service OHP clients or a finding by the Prepaid Health Plan (PHP) for members that the terms of subsection (a)(A)-(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any member, especially a member with a disability or with a co-morbid condition, providers shall determine whether the member has a funded condition/treatment pair that would entitle the member to treatment under the program, and both the funded and unfunded conditions shall be represented by an ICD-9-CM diagnosis code, or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity.

(9) The Division shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the OHP Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Division shall make a retrospective determination under this section, provided the Division is notified of the emergency situation during the next business day. If the Division denies a requested service, the Division shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the HERC Prioritized List of Health Services and the Division determines the condition/treatment pair has not been identified by the HERC for inclusion on the list, the Division shall make a coverage decision in consultation with the HERC.

(11) Coverage of services available through the OHP Benefit Package of Covered Services is limited by OAR 410-141-0500 (Excluded Services and Limitations for Oregon Health Plan Clients).

(12) General anesthesia for dental procedures that are medically and dentally appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-141-0740

Oregon Health Plan Primary Care Case Manager Quality Assurance System

(1) Primary Care Managers (PCM) shall provide services that are in accordance with accepted medical practices and with accepted professional standards:

(a) PCMs shall establish procedures and protocols for assessing quality of PCM member care:

(A) PCMs shall establish procedures for response to PCCM member complaints as outlined in OAR 410-141-0780, PCM Complaint Procedures;

(B) PCMs shall establish or adopt criteria for adequate medical care for members and shall review care received by the member against these criteria. These criteria shall include those conditions and treatments identified by the Division and the Additions and Mental Health Division (AMH) sponsored statewide-quality assurance committee as in need of study, review, or improvement;

(C) PCMs may use the services of a local medical society, other professional societies, quality assurance organizations, or professional review organizations approved by the Secretary of the U.S. to assist in reviewing criteria and protocols for the adequate medical care of members.

(b) PCMs shall maintain and improve professional competencies when needed in order to provide quality care to members.

(2) The Division and AMH conducts continuous and periodic reviews of enrollment and disenrollment, service utilization, quality of care, member satisfaction, and member medical outcomes for specific tracer conditions, accessibility, complaints, member rights, and other indicators of quality of care:

(a) The Division and AMH contract with an external medical review organization to monitor the treatment of specific conditions against national standards for treatment of tracer conditions that include, but are not limited to, asthma, anemia, diabetes, hypertension, pelvic inflammatory disease, teen pregnancy, toxemia, hypertension, and diabetes in pregnancy;

(b) The Division and AMH evaluate the management of adult and child preventive services through external medical review and through its research and evaluation program. These services are evaluated using national and state criteria including criteria for mental health and SUD treatment screenings.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

410-141-3010

CCO Application, Certification, and Contracting Procedures

(1) The following definitions apply to this rule:

(a) “Applicant” means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services;

(b) “Application” means an entity’s written response to a Request for Application (RFA);

(c) “Award Date” means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts;

(d) “Certification” means the Authority’s determination that an entity meets the criteria in OAR 410-141-3015 and the standards set forth in the RFA for being a CCO through initial certification or recertification;

(e) “Coordinated Care Services” means fully integrated physical health services, Substance Use Disorder (SUD) treatment, and mental health services and shall include dental health services as provided in ORS 414.625(3) no later than July 1, 2014;

(f) “CMS Medicare/Medicaid Alignment Demonstration” means a demonstration proposal by the Authority to CMS that will align and integrate Medicare and Medicaid benefits and financing to

the greatest extent feasible for individuals who are eligible for both programs. The Authority and CMS shall jointly establish its timelines and requirements for participation in the demonstration;

(g) “Entity” means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization;

(h) “Request for Applications (RFA)” means the document used for soliciting applications for certification as a CCO, award of or amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.

(2) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.

(3) The Authority shall use the following RFA processes for CCO certification and contracting:

(a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants will be made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;

(b) The RFA process begins with a public notice that shall be communicated using the Authority’s website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested, and a sample contract;

(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;

(d) The RFA may request applicants to appear at a public meeting to provide information about the application;

(e) The RFA will request information from applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require submission of the application on its web portal in accordance with OAR 137-047-0330 (Electronic Procurements). If electronic procurement is used, applications shall be accepted only from applicants who accept the terms and conditions for use of the Authority’s web portal.

(4) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity or other purposes within the scope of the RFA.

(5) The Authority shall evaluate applications for certification on the basis of criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;

(a) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;

(b) The Authority shall notify each applicant that applies for certification of its certification status;

(c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.

(6) Review for certification:

(a) The Authority shall issue certification only to applicants that meet the criteria in OAR 410-141-3015, meet the requirements, and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an applicant is eligible for certification when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:

(A) Provides or will provide the coordinated care services in the manner described in the RFA and the Authority's rules;

(B) Is responsible and meets or will meet standards established by the Authority and DCBS for financial reporting and solvency;

(C) Is organized and operated and shall continue to be organized and operated in the manner required by the contract and described in the application; and

(D) Shall comply with any assurances it has given the Authority.

(7) The Authority shall certify CCOs for a period of six years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.

(8) The Authority may determine that an applicant is potentially eligible for certification in accordance with section (9). The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient

applicants eligible for certification are available to attain the Authority's objectives under the RFA.

(9) The Authority may determine that an applicant is potentially eligible for certification if:

(a) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period of time; and

(b) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for certification. The Authority shall determine the date and required documentation and written assurances required from the applicant;

(c) If the Authority determines that an applicant potentially eligible for certification cannot become certified within the time announced in the RFA for contract award, the Authority may:

(A) Offer certification at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for certification within the scope of the RFA; or

(B) Inform the applicant that it is not eligible for certification.

(10) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.

(11) The Authority shall enter into or renew a contract with a CCO only if the CCO has been certified and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes, but is not limited to:

(a) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda;

(b) The number of CCOs in the region.

(12) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:

(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(b) Only an entity that the Authority has certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO that it will be offered a contract;

(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified applicants in order to meet the Authority's needs including, but not limited to, adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA;

(d) Subject to any limitations in the RFA, the Authority may renew a contract for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA;

(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.

(13) Disclosure of application contents and release of information:

(a) Except for the letter of intent to apply and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), information may not be disclosed to any applicant or the public until the award date. No information may be given to any applicant or the public relative to its standing with other applicants before the award date except under the following circumstances:

(A) The information in the application may be shared with the Authority, DCBS, CMS, and those individuals involved in the application review and evaluation process; and

(B) Information may be provided by the applicant to the public as part of a public review process.

(b) Application information may be disclosed on the award date (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA) if the Authority determines it meets the disclosure exemption requirements.

(14) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the demonstration requirements. Upon approval of the demonstration by CMS, the Authority shall conduct jointly with CMS the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and the award of three-way contracts between CMS, the state, and applicants who have been certified to contract as a CCO and participate in the demonstration.

(15) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts.

(16) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on January 1, 2012) to govern RFAs and certification and contracting with CCOs:

(a) OAR 137-046 — General Provisions Related to Public Contracting: 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 — Public Procurements for Goods or Services: OAR 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and OAR 137-047-0800;

(c) In applying the DOJ Model Rules to RFAs under this rule:

(A) An application is a proposal under the DOJ Model Rules;

(B) An RFA is an RFP under the DOJ Model Rules;

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;

(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.

(17) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3015

Certification Criteria for Coordinated Care Organizations

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO

certification within the context of the Oregon Health Policy Board's report, Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation (Jan. 24, 2012).

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above \$250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;

(b) Each criterion will be listed followed by the elements that shall be addressed during the initial certification described in this rule without limiting the information that is requested in the RFA concerning these criteria.

(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:

(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria is used to select governance structure members, and how it will assure transparency in governance;

(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;

(c) Describe how its governance structure will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.

(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC will be administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.

(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:

(a) Since community health assessments will evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before becoming certified;

(b) The applicant shall describe how it will develop its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community need that builds on community resources and skills and emphasizes innovation.

(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.

(10) Dental care organizations: On or before July 1, 2014, each CCO shall have a contractual relationship with any DCO in its service area.

(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:

(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;

(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.

(12) CCOs shall provide integrated, person-centered care and services designed to provide choice, independence, and dignity:

(a) The applicant shall describe its strategy to assure that each member receives integrated, person-centered care and services designed to provide choice, independence, and dignity;

(b) The applicant shall describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.

(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall:

(a) Describe their planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, personal health navigators, and qualified community health workers where appropriate;

(b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.

(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:

(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;

(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.

(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:

(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all members;

(b) Are educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;

(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;

(d) Are permitted to participate in the networks of multiple CCOs;

(e) Include providers of specialty care;

(f) Are selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards.

(g) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;

(h) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.

(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;

(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting. Applicants shall:

(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;

(b) Demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;

(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and Persons with Disabilities concerning care coordination and transition strategies for members.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate, and community health workers.

(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;

(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;

(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.

(21) Each CCO shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with severe and persistent mental illness covered under the State's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:

(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;

(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(22) Each CCO shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.

(23) Each CCO shall implement to the maximum extent feasible patient-centered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:

(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;

(b) The applicant shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.

(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:

(a) Describe their strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.

(25) CCOs are encouraged to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.

(26) Each CCO shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;

(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.

(27) Each CCO shall report on outcome and quality measures identified by the Authority under ORS 414.638 and participate in the All Payer All Claims (APAC) data reporting system. The applicant shall provide assurances that:

(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;

(b) It will submit APAC data in a timely manner according to program specifications.

(28) Each CCO shall be transparent in reporting progress and outcomes. Applicants shall:

(a) Describe how it will assure transparency in governance;

(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that will be transparent and publicly reported and available on the Internet.

(29) Each CCO shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:

(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;

(b) Whether the CCO will use a clinical advisory panel (CAP) or other means to ensure clinical best practices;

(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

(30) Each CCO shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:

(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Insurance Division on behalf of the Authority to confirm financial solvency and assess fiscal soundness;

(b) The applicant shall provide information relating to assets and financial and risk management capabilities.

(31) Each CCO may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.

(32) A CCO shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

(33) Each CCO shall provide covered Medicaid services, other than DHS Medicaid-funded long-term care services, to members who are dually eligible for Medicare and Medicaid. The applicant may participate in the CMS Medicare/Medicaid Alignment Demonstration if the Authority obtains necessary federal approvals.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3050

CCO Enrollment for Children Receiving Health Services

Pursuant to OAR 410-141-3060, the Authority or Oregon Youth Authority (OYA) shall select CCOs for a child receiving services in an area where a CCO is available. If a CCO is not available in an area, the Authority shall enroll the child in accordance with OAR 410-141-0050.

(1) The Authority shall to the maximum extent possible ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority unless the Authority authorizes disenrollment from a CCO:

(a) Except as provided in OAR 410-141-3060 (Coordinated Care Enrollment Requirements), OAR 410-141-3080 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO on the basis of third party resources (TPR) coverage;

(b) The Authority shall review decisions to use fee-for-service (FFS) open card for a child if the child's circumstances change and at the time of redetermination consider whether the Authority shall enroll the child in a CCO.

(2) When a child is transferred from one CCO to another CCO or from FFS or a PHP to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3160:

(a) CCOs shall work closely with the Authority to ensure continuous CCO enrollment for children;

(b) If the Authority determines that it should disenroll a child from a CCO, the CCO shall continue to provide health services until the Authority's established disenrollment date to provide for an adequate transition to the next CCO.

(3) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to the CCO's service area at the end of the temporary placement;

(b) A CAF child receiving behavioral rehabilitation services (BRS) is considered a temporary placement;

(c) Children in OYA custody enroll with the CCO serving the geographic area of placement. OYA representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary.

(4) If the Authority enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall pay for covered health services during that placement even if the location of the facility is outside the CCO's service area:

(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment;

(b) Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO unless the provisions in OAR chapter 410, division 141 apply;

(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.

(5) Except for OAR 410-141-3060 and 410-141-3080, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3120

Operations and Provision of Health Services

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, CCOs shall provide medically appropriate health services including flexible services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the contract.

(3) CCOs shall select providers using universal application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards:

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and recredentialed no less frequently than every three years. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank. CCOs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;

(b) CCOs shall screen their providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes;

(c) CCOs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be responsible for the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated:

(A) Ensuring that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;

(B) Providing training for CCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(d) The CCO shall provide accurate and timely information to the Authority about:

(A) License or certification expiration and renewal dates;

(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;

(C) If a CCO knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere").

(e) CCOs may not refer members to or use providers that:

(A) Have been terminated from the Division;

(B) Have been excluded as a Medicaid provider by another state;

(C) Have been excluded as Medicare/Medicaid providers by CMS; or

(D) Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.

(f) CCOs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. CCOs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;

(g) CCOs shall require each atypical provider to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. CCOs shall require each qualified provider to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);

(h) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

(4) A CCO may not discriminate with respect to participation in the CCO against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If a CCO declines to include individual or

groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:

(a) Require that a CCO contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or

(b) Preclude the CCO from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:

(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or

(B) Factors that add value to the service provided including, but not limited to, expertise, experience, accessibility, or cultural competence.

(c) The requirements in subsection (b) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.

(5) A CCO shall establish an internal review process for a provider aggrieved by a decision under section (4) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.

(6) To resolve appeals made to the Authority under sections (4) and (5) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the CCO to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the CCO's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(7) A prevailing party in an appeal under sections (4) through (6) of this rule shall be awarded the costs of the appeal.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3145

Community Health Assessment and Community Health Improvement Plans

(1) Pursuant to ORS 414.627 to the extent practicable, CCOs shall partner with their local public health authority, local mental health authority, and hospital systems to develop a shared Community Health Assessment (CHA) process including conducting the assessment and development of the resulting Community Health Improvement Plan (CHP).

(2) CCOs shall work with the Authority to identify the components of the CHA. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, the Early Learning Council, the Youth Development Council, and school health providers in the region using existing resources when available and avoiding duplication where practicable.

(3) In developing and maintaining a health assessment, CCOs shall meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including, but not limited to, the following:

- (a) Emphasis on disproportionate, unmet, health-related need;
- (b) Emphasis on primary prevention;
- (c) Building a seamless continuum of care;
- (d) Building community capacity;
- (e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a CHA and CHP will be met for purposes of ORS 414.627 if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007, and the Public Health Accreditation Board CHA and CHP requirements for local health departments and the AAA and local mental health authority in the process.

(5) The CCO's CAC shall oversee the CHA and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the CHP.

(6) The CHP adopted by the Council shall describe the scope of the activities, services, and responsibilities that the CCO shall consider upon implementation. The activities, services, and responsibilities defined in the CHP may include, but are not limited to:

- (a) Analysis and development of public and private resources, capacities, and metrics based on ongoing community health assessment activities and population health priorities;
- (b) Health policy;

- (c) System design;
- (d) Outcome and quality improvement;
- (e) Integration of service delivery;
- (f) Workforce development; and
- (g) Public Health Accreditation Board standards for CHPs.

(7) CCOs and their participating providers shall work together to develop best practices of culturally and linguistically appropriate care and service delivery to eliminate health disparities and improve member health and well-being.

(8) CCOs and their CAC shall collaborate with the Authority's Office of Equity and Inclusion to develop meaningful baseline data on health disparities. CCOs shall include in the CHA identification and prioritization of health disparities among CCOs' diverse communities, including those defined by race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting including, but not limited to, home independent support living, adult foster home, or homeless. CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority. CCOs shall also include representatives of populations experiencing health disparities in CHA and CHP prioritization. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCOs shall make this information available by posting on the web.

(9) To the extent practicable, CCOs shall:

- (a) Base the CHP on research including research into adverse childhood experiences;
- (b) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system;
- (c) Improve the integration of all services provided to meet the needs of children, adolescents, and families;
- (d) Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents;
- (e) With the development of its CHP SBHCs, school nurses, school mental health providers, and individuals representing child and adolescent health services shall be included.

(10) CCOs shall develop and review and update its CHA and plan at least every five years to ensure the provision of all medically appropriate covered coordinated care services including

urgent care and emergency services, preventive, community support, and ancillary services in those categories of services included in CCO contracts or agreements with the Authority.

(11) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(12) If there is more than one CCO in a community, the CCOs and their community partners may work together to develop one shared CHA and one shared CHP.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3200

Outcome and Quality Measures

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

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

(3) CCOs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health treatment, oral health care (to the extent that dental services are the responsibility of a CCO under an agreement with a DCO), and all other health services provided by or under the responsibility of the CCO as specified in the CCO's contract with the Authority.

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

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction;

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3260; and

(d) Assess the quality and appropriateness of coordinated care services provided to members who are aged, blind, or disabled who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services; who received Medicaid funded long-term care benefits; or who are children receiving CAF (Child Welfare) or OYA services.

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

(6) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 that address physical health care, behavioral health treatment, or dental care concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.

(7) CCOs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures will be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health);

(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation and require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

(8) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3270

Coordinated Care Organization Marketing Requirements for Potential Members

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

(a) “Cold-call Marketing” means any unsolicited personal contact with a potential member for the purpose of marketing by the CCO.

(b) “Marketing” means any communication from a CCO to a potential member who is not enrolled in the CCO that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(c) “Marketing Materials” means materials that are produced in any medium by or on behalf of a CCO and that can reasonably be interpreted as intended to market to potential members.

(d) “Outreach” means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO’s subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.

(e) “Outreach Materials” means materials that are produced in any medium, by or on behalf of a CCO that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO.

(f) “Potential Member” means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO.

(2) CCOs shall comply with 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the CCO provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that CCO. CCOs shall distribute the materials to its entire service area as indicated in its CCO contract. The CCOs may not:

(a) Distribute any marketing materials without first obtaining state approval;

(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and

(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The following communications are expressly permitted:

(a) The creation of name recognition and communication methodologies may include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(b) A CCO or its subcontractor’s communications that express participation in or support for a CCO by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client’s enrollment.

(4) CCOs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm information before posting.

(5) CCOs have sole accountability for producing or distributing materials following Authority approval.

(6) CCOs shall comply with the Authority marketing materials submission guidelines. CCOs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with CCO marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

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

Stats. Implemented: ORS 414.610 – 685