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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

PCCM Program Dissolution of Rules and Program References

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

410-141-0000, 410-141-0080, 410-141-0160, 410-141-0220, 410-141-0320, 410-141-0340, 410-141-0420, 410-141-0860, 410-141-3080

REPEAL:

410-141-0085, 410-141-0410, 410-141-0660, 410-141-0680, 410-141-0700, 410-141-0720, 410-141-0740, 410-141-0760, 410-141-0780, 410-141-0800, 410-141-0820, 410-141-0840

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 413.042

RULE SUMMARY

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 the Authority issuing a final

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

(3) “Capitated Services” means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.

(4) “Capitation Payment” means monthly prepayment to a PHP for health services the PHP provides to members.

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

(6) “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.

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

(8) “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.

(9) “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 take into consideration the community standard and be adequate to meet the needs of the Division.

(10) “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.

(11) “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.

(12) “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.

(13) “Coordinated Care Services” mean a CCO’s fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(14) “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.

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

(16) “Dental Case Management Services” means services provided to ensure the 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.

(17) “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.

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

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

(20) “Exceptional Needs Care Coordination (ENCC)” means for PHPs a specialized case management service provided by FCHPs to members identified as aged, blind, or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those members who are aged, blind, or disabled who have complex medical needs;

(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 community support and social service systems linkage with medical care systems, as necessary and appropriate.

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

(22) “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.

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

(24) “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.

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

(26) “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.

(27) “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.

(28) “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.

(29) “Home CCO” means enrollment in a CCO in a given service area based upon a client’s most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization.

(30) “Intensive Case Management (ICM)” means a specialized case management service provided by CCOs 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.

(31) “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.

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

(33) “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.

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

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

(36) “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.

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

(38) “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.

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

(40) “Other Non-Medical Services” means non-state plan, health related services, also referred to as “flexible services.” These services are provided in-lieu of traditional benefits and are intended to improve care delivery, member health, and lower costs. Services may effectively treat or prevent physical or behavioral healthcare conditions. Services are consistent with the member’s treatment plan as developed by the member’s primary care team and documented in the member’s medical record.

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

(42) “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.

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

(44) “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.

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

(46) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy is designed in collaboration with the member, the member’s family, or the member representative and may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0080

Managed Care Disenrollment from Prepaid Health Plans

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

(1) All Oregon Health Plan (OHP) member-initiated requests for disenrollment from a Prepaid Health Plan (PHP) shall be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035 and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority and PHP shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Newly eligible members may change their PHP assignment within 12 months following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months;

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

(D) In accordance with ORS 414.645, members may disenroll from a PHP during their redetermination (enrollment period) or one additional time during their enrollment period based on the members choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

(B) Members who disenroll from a Medicare Advantage plan shall also be disenrolled from the corresponding PHP. The effective date of disenrollment shall be the first of the month that the member's Medicare Advantage plan disenrollment is effective;

(C) Members who are receiving Medicare (dual eligible) and who are enrolled in a PHP that has a corresponding Medicare Advantage component shall be disenrolled from the PHP if the contractor has declared its decision to disenroll members in accordance with OAR 410-141-0060 in the annual Dual Eligible Clients with Medicare Advantage Plans (Schedule 5) form. The effective date of disenrollment from the PHP shall be the first of the month following the date of request for disenrollment. Dual eligible shall receive choice counseling prior to reassignment;

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

(E) The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(F) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the PHP's service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of a member or a provider of a treatment, service, or supply including, but not limited to, a decision of a provider to participate or decline to participate in a PHP;

(iv) As specified in ORS 414.645, the Authority may approve the transfer of 500 or more members from one PHP to another PHP if:

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

(II) Members are offered the choice of remaining enrolled in the transferring PHP; and

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

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

(V) Members may not be transferred under section 2(E)(vi) until the Division has evaluated the receiving PHP and determined that the PHP meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the PHP maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(G) Members whose request for disenrollment is denied shall receive notice in accordance with OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing over the denial.

(c) If the following conditions are met:

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

(B) The new PHP the member is enrolled with does not contract with the member's current OB provider, and the member wishes to continue obtaining maternity services from that non-participating OB provider; and

(C) The request to change PHP or return to FFS is made prior to the date of delivery;

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

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

(B) Involuntary transfer of a member from a PHP to another PHP; or

(C) Automatic enrollment of a member in a PHP.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another PHP unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment as stated in 410-141-0060(4), and the member meets disenrollment criteria state in 42 CFR 438.56(c)(2), or there isn't another PHP in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

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

(3) The PHP may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

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

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

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the PHP disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(4) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the PHP requests it for cause that includes, but is not limited to, the following:

(a) Member commits fraudulent or illegal acts related to the member's participation in OHP such as: permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The PHP shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 1-888-Fraud01 (1-888-372-8301) or <http://www.oregon.gov/DHS/aboutdhs/Pages/fraud/index.aspx> consistent with 42 CFR 455.13;

(b) Member became eligible through a hospital hold process and placed in the Adults and Couples category as required under 410-141-0060(4).

(c) Requests by the PHP for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The PHP shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made;

(B) There shall be notification from the provider to the PHP at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the PHP. Such notification shall be documented in the member's clinical record. The PHP shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The PHP shall contact the member either verbally or in writing if it is a severe problem to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issues. Any contact with the member shall be documented in the member's clinical record. The PHP shall inform the member that their continued behavior may result in disenrollment from the PHP;

(D) The PHP shall provide individual education, disability accommodation, counseling, and other interventions with the member in a serious effort to resolve the problem;

(E) The PHP shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the PHP shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The PHP shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

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

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others shall actually occur, and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A PHP-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

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

(vi) If a Primary Care Provider (PCP) terminates the member as a patient, the PHP shall attempt to locate another PCP on their panel who will accept the member as their patient. If needed, the PHP shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of members as patients shall be according to the PHP's policies and shall be consistent with PHP or PCP's policies for commercial members and with applicable disability discrimination laws. The PHP shall determine whether the PCP's termination of the member as a patient is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements as stated above, requests by the PHP for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56, the PHP shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the PHP's staff so that it seriously impairs the PHP's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member will cause grievous physical injury to others (including, but not limited to, death) in the near future, and that risk cannot be eliminated

by a modification of policies, practices, or procedures. The PHP shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an Exception to the Disenrollment Process of a Member;

(B) The provider shall immediately notify the PHP about the incident with the member. The notification shall describe the problem and shall be maintained for documentation purposes;

(C) The PHP shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;

(D) The PHP shall provide any additional information requested by the CAR, the Authority, or Department of Human Services assessment team;

(E) If the member's behavior could reasonably be perceived as the result of his or her special needs or disability, the PHP shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined above;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others will actually occur, and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(F) Documentation shall exist that verifies the provider or PHP immediately reported the incident to law enforcement. The PHP shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinic record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures will not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

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

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the PHP's CAR or a team of CARs who may request additional information from Ombudsman Services or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;

(B) In cases where the member is also enrolled in the PHP's Medicare Advantage plan, the PHP shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is not sufficient documentation, the CAR shall notify the PHP within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the PHP of the decision within ten working days of receipt of sufficient documentation from the PHP;

(E) Written decisions including reasons for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(5) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the PHP and the member's care team;

(b) The notice shall give the reason for the denial of the disenrollment request and the notice of a member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing in accordance with 42 CFR 438.56;

(c) Written decisions including the reason for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(6) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the PHP and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will proceed unless the member requests continued enrollment, pending a decision;

(c) The disenrollment effective date will be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment, pending a hearing decision. The disenrollment will take effect immediately upon the issuing of a hearing officer's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another PHP;

(e) If no other PHP is available to the member, the member will be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same PHP for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the PHP again requests disenrollment for cause, the request shall be referred to the OHA assessment team for review.

(7) Other reasons for the PHP's request for disenrollment shall include the following:

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

(b) The member has surgery scheduled at the time their enrollment is effective with the PHP, the provider is not on the PHP's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the PHP;

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

(e) Excluding the DCOs, if the PHP determines that the member has Third Party Liability (TPL), the PHP will contact the Health Insurance Group (HIG) to request disenrollment;

(f) If a PHP has knowledge of a member's change of address, the PHP shall notify the member's care team. The care team shall verify the address information and disenroll the member from the PHP, if the member no longer resides in the PHP's service area. Members shall be disenrolled if out of the PHP's service area for more than three months, unless previously arranged with the PHP. The effective date of disenrollment shall be the date specified by the Division and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the PHP;

(g) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been

adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the members and providing sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from PHPs for members who have been taken into custody;

(h) The member is in a state psychiatric institution.

(8) The Division has authority to initiate and disenroll members as follows:

(a) If informed that a member has a third party insurer (TPL), the Division shall refer the case to the HIG for investigation and possible exemption from PHP enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the PHP's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the PHP;

(c) If the member is no longer eligible for the Oregon Health Plan, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(9) Unless specified otherwise in these rules or in the Division notification of disenrollment to the PHP, all disenrollments are effective the end of the month the Authority approves the request with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated.

(b) The Authority may retroactively disenroll enrollment if the member has TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

Stat. Auth.: ORS 413.042, 414.645, 414.647

Stats. Implemented: ORS 414.065, 414.645, 414.647

410-141-0160

Oregon Health Plan Prepaid Health Plan (PHP) Coordination and Continuity of Care

(1) PHPs shall have written policies, procedures, and monitoring systems that ensure the provision of Medical Case Management Services and delivery of primary care to and coordination of health care services for all members:

(a) PHPs are to coordinate and manage capitated services and non-capitated services and ensure that referrals made by the PHP's providers to other providers for covered services are noted in the appropriate Division member's clinical record;

(b) PHPs shall ensure members receiving Exceptional Needs Care Coordination (ENCC) services for the aged, blind, or disabled who have complex medical needs as described in 410-141-0405 are noted in the appropriate Division member's record. ENCC is a service available through Fully Capitated Health Plans (FCHPs) or Physician Care Organizations (PCOs) that is separate from and in addition to medical case management services;

(c) These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a practitioner or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with OAR 410-141-0120;

(d) FCHPs and PCOs 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. FCHPs and PCOs shall document all monitoring and corrective action activities:

(A) PHPs shall develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by contracts/agreements with the Division). PHPs shall ensure that access to and quality of care provided in all referral settings is monitored. Referral services and services received in alternative care settings shall be reflected in the member's clinical record. PHPs shall establish and follow written procedures for participating and non-participating providers in the PHP's referral system. Procedures shall include the maintenance of records within the referral system sufficient to document the flow of referral requests, approvals, and denials in the system;

(B) 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, except when the member is enrolled in a Medicare HMO or Medicare Advantage FCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or Medicare Advantage and MHOs have significant and shared responsibility for prepaid services and shall coordinate benefits for the member to ensure that the member receives all medically appropriate services covered under respective capitation payments;

(ii) If the member is enrolled in a FCHP or PCO with a Medicare HMO component or Medicare Advantage, then Medicare covered mental health services shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO, respectively. Mental health services that are not covered by the FCHP or PCO but are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(C) PHPs shall have written procedures for referrals that ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the member's clinical record;

(D) PHPs shall designate a staff member who is responsible for the arrangement, coordination, and monitoring of the PHP's referral system;

(E) PHPs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional;

(F) PHPs shall have written procedures that ensure relevant medical, mental health, and dental information is obtained from referral providers including telephone referrals. These procedures shall include:

(i) Review of information by the referring provider;

(ii) Entry of information into the member's clinical record;

(iii) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral providers, reviewed by the referring practitioner, and entered into the clinical record.

(G) PHPs shall have written procedures to orient and train their staff, participating practitioners and their staff, the staff in alternative care settings, and staff in urgent and emergency care facilities in the appropriate use of the PHP's referral, alternative care, and urgent and emergency care systems. Procedures and education shall ensure use of appropriate settings of care;

(H) PHPs shall have written procedures that ensure an appropriate staff person responds to calls from other providers requesting approval to provide care to members who have not been referred to them by the PHP. If the person responding to the call is not a health care professional, the PHP shall have established written protocols that clearly describe when a health care professional needs to respond to the call. These procedures and protocols shall be reviewed by the PHP for appropriateness. The procedures shall address notification of acceptance or denial and entry of information into the PCP's clinical record;

(I) FCHPs and PCOs shall have written policies and procedures to ensure information on all emergency department visits is entered into the member's appropriate PCP's clinical record. FCHPs and PCOs shall communicate this policy and procedure to providers, monitor providers' compliance with this policy and procedure, and take corrective action necessary to ensure compliance;

(J) If a member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:

(i) A notation is made in the member's appropriate PCP's clinical record of the reason, date, and expected duration of the hospitalization;

(ii) Upon discharge, a notation is made in the member's appropriate PCP's clinical record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and

(iii) Pertinent reports from the hospitalization are entered in the member's appropriate PCP's clinical record. Such reports shall include, as applicable, the reports of consulting practitioners' physical history, psycho-social history, list of medications and dosages, progress notes, and discharge summary.

(2) For members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure the member has timely and appropriate access to covered services and to ensure coordination of care provided by the PHP and care provided by the facility or home. PHPs shall make provisions for a PCP or the facility's "house doctor or dentist" to provide care to members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For members living in residential facilities or homes providing ongoing care, FCHPs and PCOs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs and PCOs shall provide emergency prescriptions on a 24-hour basis.

(4) For members who are discharged to post hospital extended care, the FCHP shall notify the appropriate Authority office at the time of admission to the skilled nursing facility (SNF) and begin appropriate discharge planning. The FCHP is not responsible for the post hospital extended care benefit unless the member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the member no later than two full working days prior to discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the appropriate DHS office shall be notified at the time the FCHP learns of the admission. The FCHP shall initiate appropriate discharge planning at the time of the notification to the Authority office.

(5) PHPs shall coordinate the services the PHP furnishes to members with the services the member receives from any other PHP (FCHP, PCO, DCO, CDO, or MHO) in accordance with OAR 410-141-0120 (6). PHPs shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.

(6) When a member's care is being transferred from one PHP to another or for clients transferring from fee-for-service to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the client into the care of a PHP participating provider.

(7) PHPs shall make attempts to contact targeted Division populations by mail, telephone, in person, or through the Authority within the first three months of enrollment to assess medical, mental health, or dental needs appropriate to the PHP. The PHP shall, after reviewing the

assessment, refer the member to his PCP or other resources as indicated by the assessment. Targeted populations shall be determined by the PHP and approved by the Division.

(8) MHOs shall establish working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area for the purposes of maintaining a comprehensive and coordinated mental health delivery system and to help ensure member access to mental health services that are not provided under the capitation payment.

(9) MHOs shall ensure that members receiving services from extended or long term psychiatric care programs (e.g., secure residential facilities, PASSAGES projects, state hospital) will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.

(10) MHOs shall coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for members requiring services from more than one public agency. This approach shall help avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive treatment setting (e.g., clinic, home, school, community).

(12) MHOs shall consult with and provide technical assistance to FCHPs and PCOs to help assure that mental health conditions of members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

410-141-0220

Managed Care Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all members. 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 participating provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between members and non-members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures that ensure for 90 percent of their members in each service area, routine travel time or distance to the location of the PCP does not exceed

the community standard for accessing health care participating providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by the Division:

(A) In urban areas: 30 miles, 30 minutes, or the community standard, whichever is greater;

(B) In rural areas: 60 miles, 60 minutes, or the community standard, whichever is greater.

(b) PHPs shall maintain and monitor a network of appropriate participating providers sufficient to ensure adequate service capacity to provide availability of and timely access to medically appropriate covered services for members:

(A) PHPs shall have an access plan that establishes standards for access, outlines how capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision, and ancillary services as accessible to members in terms of timeliness, amount, duration, and scope as those services are to non- members within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to the Division and shall provide reasonable alternatives for members to access care that must be approved by the Division. PHPs shall demonstrate to the Division that it surveys and monitors for equal access of member referrals to provider, pharmacy, hospital, vision, and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled who have complex medical needs or who are children receiving CAF (SOSCF services) or OYA services have access to primary care, dental care, mental health providers, and referral, as applicable. These providers shall have the expertise to treat, take into account, and accommodate the full range of medical, dental, or mental health conditions experienced by these members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs enrollment standards:

(a) PHPs shall remain open for enrollment unless the Authority has closed enrollment because the PHP has exceeded their enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by the Division and the PHP;

(b) PHPs enrollment may also be closed by the Division due to sanction provisions;

(c) PHPs shall accept all clients, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Division to provide covered services;

(d) PHPs may confirm the enrollment status of a client by one of the following:

(A) The individual's name appears on the monthly or weekly enrollment list produced by the Division;

(B) The individual presents a valid medical care identification that shows he or she is enrolled with the PHP;

(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the PHP;

(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the PHP.

(e) PHPs shall have open enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, members shall be automatically enrolled in the succeeding PHP. The member will have 30 calendar days to request disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding PHP.

(4) If a PHP engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area and necessitates either transferring members to other providers or the PHP withdrawing from part or all of a service area, the PHP shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:

(a) A PHP may provide less than the required 90 calendar-day notice to the Authority upon approval by the Authority when the PHP must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the PHP and refuses to provide the required 90 calendar-day notice;

(b) If DHS must notify members of a change in participating providers or PHPs, the PHP shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide members with at least a 30 calendar-day notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit:

(a) PHPs shall have written policies and procedures and a monitoring system to assure that members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

(i) Emergency Care: The member shall be seen immediately or referred to an emergency department depending on the member's condition;

(ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening, in accordance with OAR 410-141-0140; and

(iii) Well Care: The member shall be seen within four weeks or within the community standard.

(B) DCOs:

(i) Emergency Care: The member shall be seen or treated within 24-hours;

(ii) Urgent Care: The member shall be seen within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(iii) Routine Care: The member shall be seen for routine care within an average of eight weeks and within twelve weeks or the community standard, whichever is less, unless there is a documented special clinical reason that would make access longer than 12 weeks appropriate.

(C) MHOs:

(i) Emergency Care: The member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care: The member shall be seen for an intake assessment within two weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of members through the office such that members are not kept waiting longer than non-member patients under normal circumstances. If members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through complaint and appeal reviews, termination reports, and member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with members when participating providers have notified the PHP that the members have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed medically or dentally appropriate, documentation in the clinical record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the PHP's participating provider office or clinic, PHPs shall provide outreach services as medically appropriate;

(d) PHPs shall have policies and procedures that ensure participating providers will attempt to contact members if there is a need to cancel or reschedule the member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to triage the service needs of members who walk into the PCP's office or clinic with medical, mental health, or dental care needs. Such triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the member's needs or be evaluated for treatment within two hours by a medical, mental health, or dental provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by the Division because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate clinical record of the Division member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental provider must be consulted. When medically appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the Division member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's participating providers) have sufficient communication skills and training to reassure members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's quality improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health, or dental care visits including home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to be able to understand the member's complaint, to make a diagnosis, to respond to the member's questions and concerns, and to communicate instructions to the member;

(c) PHPs shall ensure the provision of care and interpreter services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the member;

(d) PHPs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating referral providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether members are receiving accommodations for access and to determine what will be done to remove existing barriers and to accommodate the needs of members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all members including, but not limited to, the following:

(i) Street level access or accessible ramp into the facility;

(ii) Wheelchair access to the lavatory;

(iii) Wheelchair access to the examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that participating providers, their facilities, and personnel are prepared to meet the complex medical needs of members who are aged, blind, or disabled:

(A) PHPs shall have a written plan for meeting the complex medical needs of members who are aged, blind, or disabled;

(B) PHPs shall monitor participating providers for compliance with the access plan and take corrective action when necessary.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0320

Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure Division of Medical Assistance Programs (Division) members have the rights and responsibilities included in this rule:

(a) PHPs shall communicate these policies and procedures to participating providers;

(b) PHPs shall monitor compliance with policies and procedures governing member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) The members shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by participating providers the same as other people seeking health care benefits to which they are entitled;

(c) To choose a PHP as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;

- (e) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;
- (f) To be actively involved in the development of the member's treatment plan;
- (g) To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;
- (h) To consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;
- (i) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- (j) To have written materials explained in a manner that is understandable to the member;
- (k) To receive necessary and reasonable services to diagnose the presenting condition;
- (L) To receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and is medically appropriate;
- (m) To obtain covered preventive services;
- (n) To have access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;
- (o) To receive a referral to specialty practitioners for medically appropriate covered services;
- (p) To have a clinical record maintained that documents conditions, services received, and referrals made;
- (q) To have access to one's own clinical record unless restricted by statute;
- (r) To transfer a copy of the member's clinical record to another provider;
- (s) To execute a statement of wishes for treatment including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act;
- (t) To receive written notices before a denial of or change in a benefit or service level is made unless such notice is not required by federal or state regulations;
- (u) To know how to make a complaint or appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-141-0266;

- (v) To request an administrative hearing with the Authority;
 - (w) To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and
 - (x) To receive a notice of an appointment cancellation in a timely manner.
- (3) The member shall have the following responsibilities:
- (a) To choose or help with assignment to a PHP as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements and a PCP or service site;
 - (b) To treat the PHP, practitioner, and clinic staff with respect;
 - (c) To be on time for appointments made with practitioners and other providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;
 - (d) To seek periodic health exams and preventive services from a PCP or clinic;
 - (e) To use a PCP or clinic for diagnostic and other care except in an emergency;
 - (f) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
 - (g) To use urgent and emergency services appropriately and notify the PHP within 72 hours of an emergency;
 - (h) To give accurate information for inclusion in the clinical record;
 - (i) To help the practitioner, provider, or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
 - (j) To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;
 - (k) To use information to make informed decisions about treatment before it is given;
 - (L) To help in the creation of a treatment plan with the provider;
 - (m) To follow prescribed, agreed upon treatment plans;
 - (n) To tell the practitioner or provider that the member's health care is covered under OHP before services are received and, if requested, to show the practitioner or other provider the Division Medical Care Identification form;
 - (o) To tell the Authority worker of a change of address or phone number;

- (p) To tell the Authority worker if the member becomes pregnant and to notify the Authority worker of the birth of the member's child;
- (q) To tell the Authority worker if any family members move in or out of the household;
- (r) To tell the Authority worker if there is any other insurance available;
- (s) To pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
- (t) To pay the monthly OHP premium on time if so required;
- (u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;
- (v) To bring issues or complaints or grievances to the attention of the PHP; and
- (w) To sign an authorization for release of medical information so that the Authority and the PHP can get information that is pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

410-141-0340

Oregon Health Plan Prepaid Health Plan Financial Solvency

(1) Prepaid Health Plans (PHPs) shall assume the risk for providing capitated services under their contracts and agreements with the Division of Medical Assistance Programs (Division). PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division:

(a) PHPs shall comply with solvency requirements specified in contracts and agreements with the Division. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts and agreements with the Division. If the PHP has contracts and agreements with the Division, separate restricted reserve fund accounts shall be maintained for each contract and agreement;

(B) Protection against catastrophic and unexpected expenses related to capitated services for PHPs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance, or any other alternative determined acceptable by the Division. Self-insurance must be determined appropriate by the Division;

(C) Maintenance of professional liability coverage of not less than \$1,000,000 per person per incident and not less than \$1,000,000 in the aggregate either through binder issued by an insurance carrier or by self-insurance with proof of same, except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;

(D) Systems that capture, compile, and evaluate information and data concerning financial operations. Such systems shall provide for the following:

- (i) Determination of future budget requirements for the next three quarters;
- (ii) Determination of incurred but not reported (IBNR) expenses;
- (iii) Tracking additions and deletions of members and accounting for capitation payments;
- (iv) Tracking claims payment;
- (v) Tracking all monies collected from third party resources on behalf of members; and
- (vi) Documentation of and reports on the use of incentive payment mechanisms, risk-sharing, and risk-pooling, if applicable.

(b) PHPs shall submit the following applicable reports as specified in agreements with the Division:

(A) An annual audit performed by an independent accounting firm containing, but not limited to:

- (i) A written statement of opinion by the independent accounting firm, based on the firm's audit regarding the PHP's financial statements;
- (ii) A written statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities, and related items;
- (iii) Balance Sheets;
- (iv) Statement of Revenue, Expenses and Net Income, and Change in Fund Balance;
- (v) Statements of Cash Flows;
- (vi) Notes to Financial Statements;
- (vii) Any supplemental information deemed necessary by the independent accounting firm or actuary; and
- (viii) Any supplemental information deemed necessary by the Division.

(B) PHP-specific quarterly financial reports. Such quarterly reports shall include, but are not limited to:

- (i) Statement of Revenue, Expenses and Net Income;
- (ii) Balance Sheet;
- (iii) Statement of Cash Flows;
- (iv) Incurred But Not Reported (IBNR) Expenses;
- (v) Fee-for-service liabilities and medical and hospital expenses that are covered by risk-sharing arrangements;
- (vi) Restricted reserve documentation;
- (vii) Third party resources collections (MHO Contractor); and
- (viii) Corporate Relationships of Contractors (FCHPs, DCOs, and PCOs) or Incentive Plan Disclosure and Detail (MHOs).

(C) PHP-specific utilization reports;

(D) PHP-specific quarterly documentation of the Restricted Reserve. Restricted reserve funds of FCHPs, PCOs, and DCOs shall be held by a third party. Restricted reserve fund documentation shall include the following:

- (i) A copy of the certificate of deposit from the party holding the restricted reserve funds;
- (ii) A statement showing the level of funds deposited in the restricted reserve fund accounts;
- (iii) Documentation of the liability that would be owed to creditors in the event of PHP insolvency;
- (iv) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.

(2) MHOs shall comply with the following additional requirements regarding restricted reserve funds:

- (a) MHOs that subcontract any work described in agreements with the Division may require subcontractors to maintain a restricted reserve fund for the subcontractor's portion of the risk assumed or may maintain a restricted reserve fund for all risk assumed under the agreement with the Division. Regardless of the alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with the Division;

(b) If the restricted reserve fund of the MHO is held in a combined account or pool with other entities, the MHO and its subcontractors, as applicable, shall provide a statement from the pool or account manager that the restricted reserve fund is available to the MHO or its subcontractors, as applicable, and has not been obligated elsewhere;

(c) If the MHO must use its restricted reserve fund to cover services under its agreement with the Division, the MHO shall provide advance notice to the Division of the amount to be withdrawn, the reason for withdrawal, when and how the restricted reserve fund will be replenished, and steps to be taken to avoid the need for future restricted reserve fund withdrawals;

(d) MHOs shall provide the Division access to restricted reserve funds if insolvency occurs;

(e) MHOs shall have written policies and procedures to ensure that if insolvency occurs, members and related clinical records are transitioned to other MHOs or providers with minimal disruption.

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

(1) Providers shall submit all billings for members following these timeframes:

(a) Submit billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

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

(C) When Medicare is the primary payer, except where the MCO is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the MCO, which does not include failure of the provider to certify the 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 payers of last resort and are not considered an alternative liability or TPL.

(b) Submit billings within four months of the date of service for all other cases.

(2) Providers must be enrolled with the Division to be eligible for Authority 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 Division before enrollment with the Authority 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 Authority as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted.

(4) Providers shall verify before providing services that the member is eligible for the Division's programs on the date of service using the Authority and PHP's tools, as applicable, and that the service to be provided is covered under the member's OHP Benefit Package. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete and have the member sign an Authority 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 Authority 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) PHPs shall have written procedures for processing preauthorization requests received from any provider and written procedures for processing claims submitted from any source. The procedures shall specify time frames for:

(A) Date stamping preauthorization requests and claims when received;

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

(C) The specific number of days allowed for follow-up on pending preauthorization requests or pending claims to obtain additional information;

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

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

(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of 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:

(A) 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;

(B) The PHP may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the PHP justifies to the Authority a need for additional information and how the extension is in the member's best 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 as outlined in OAR 410-141-0263. 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 Authority upon request the need for additional information and how the delay is in the member's best 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;

(e) 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;

(f) 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;

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

(h) 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;

(i) PHPs may 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;

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

(7) 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.

(8) 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 have arranged and authorized when those services are available within the state, unless otherwise approved by the Authority.

(9) 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 pay non-participating providers (providers enrolled with the Authority 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.

(10) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (10)–(12) only apply to services provided by Type A or Type B hospitals to clients or members that are enrolled in a PHP;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority on a case-by-case basis require PHPs to continue to fully reimburse a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio.

(11) Redetermination of which Type A or Type B hospitals will transition off of CBR:

(a) No later than April 30, 2015, the Authority shall update the algorithm for calculation of the CBR methodology with the most recent data available;

(b) After recalculation for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1, 2016;

(c) The reimbursement methodology for each hospital shall be recalculated every two years thereafter;

(d) Type A and Type B hospitals located in a county that is designated as “Frontier” will not be subject to redetermination via the algorithm and shall remain on CBR.

(12) Non-contracted Type A or Type B hospital rates for those transitioning off of CBR:

(a) Charges shall be discounted for both inpatient and outpatient services. The initial reimbursement rate effective January 1, 2015 shall be based on the individual hospital’s most recently filed Medicare cost report adjusted to reflect the hospital’s Medicaid/OHP mix of services;

(b) Reimbursement rates effective for the calendar year beginning January 1, 2016 shall be based on the hospital’s most recently filed Medicare cost report adjusted to reflect the hospital’s Medicaid/OHP mix of services and further adjusted by the Actuarial Services Unit (ASU) based on the individual hospital’s annual price increases during FY 2014–FY 2015 and the Authority’s global budget rate increase as defined by the CMS 1115 waiver using the following formula:
Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(c) Subsequent year reimbursement rates shall be adjusted and calculated by the Actuarial Services Unit (ASU) based on the individual hospital’s annual price increase and the Authority’s global budget rate increase as defined by the CMS 1115 waiver using the following formula:
Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) ASU shall contact hospitals regarding price increases during March of each year;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) A volume adjustment shall also be applied. ASU shall develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority shall determine when the volume adjustment might sunset on a hospital specific basis;

(g) Non-contracted Type A or Type B hospital reimbursement rates for those transitioning off of CBR can be found in the Rate Table section at the following:
<http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx>.

(13) Members enrolled with PHPs may receive certain services on a FFS basis:

(a) 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 paid by the Authority on a FFS basis. Before providing services, providers shall verify a member’s eligibility via the web portal or AVR;

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

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority 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 contracts, billing instructions, and Authority administrative rules and supplemental information;

(e) The Authority may not pay a provider for providing services for which a PHP has received a capitation payment unless otherwise provided for in rule;

(f) 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 or PHP except as provided for in Authority administrative rules and supplemental information (e.g., capitated services that are not included in the nursing facility all-inclusive rate); and

(g) 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 Balanced Budget Act (BBA) 4712(b)(2).

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

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

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

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

(c) The Authority 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 Authority administrative rules and supplemental information.

(16) Clients not enrolled with a PHP receive services on a FFS basis:

(a) Services may be received directly from any appropriately enrolled provider;

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

(c) The Authority 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 Authority administrative rules and supplemental information.

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

410-141-0860

Oregon Health Plan Patient Centered Primary Care Home Provider Qualification and Enrollment

CCOs shall administer the Patient Centered Primary Care Home program and receive program required reporting as supposed by OAR 409-055-0000 through OAR 409-055-0090 and the 2016 CCO contract.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-141-3080

Disenrollment from Coordinated Care Organizations

(1) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) or Dental Care Organization (DCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO or DCO, where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority, CCO, or DCO shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Newly eligible members may change their CCO or DCO assignment within 12 months following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months;

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

(D) In accordance with ORS 414.645, members may disenroll from a CCO or DCO during their redetermination (enrollment period) or one additional time during their enrollment period based on the member's choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

(B) Due to moral or religious objections, the CCO or DCO does not cover the service the member seeks;

(C) When the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the CCO or DCO's service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060 or this rule. Participation in the Oregon Health Plan, including coordinated care or dental care, does not guarantee that any member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of a member or a provider of a treatment, service, or supply including, but not limited to, a decision of a provider to participate or decline to participate in a CCO or DCO;

(iv) As specified in ORS 414.645, the Authority may approve the transfer of 500 or more members from one CCO or DCO to another CCO or DCO if:

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

(II) Members are offered the choice of remaining enrolled in the transferring CCO or DCO; and

(III) The member and all family (case) members shall be transferred to the provider's new CCO or DCO; and

(IV) The transfer shall take effect when the provider's contract with their current CCO or DCO contractual relationship ends or on a date approved by the Division; and

(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO or DCO and determined that the CCO or DCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO or DCO maintains a network of providers sufficient in numbers, areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing.

(c) If the following conditions are met:

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

(B) The new CCO or DCO the member is enrolled with does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider; and

(C) The request to change CCO or DCO or return to FFS is made prior to the date of delivery.

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

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

(B) Involuntary transfer of a member from a CCO or DCO to another CCO or DCO; or

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

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another CCO or DCO, unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060(4) or 410-141-0060(4), the member meets disenrollment criteria state in 42 CFR 438.56(c)(2), or there is not another CCO or DCO in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

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

(3) The CCO or DCO may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

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

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

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO or DCO disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(4) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO or DCO requests it for cause that includes, but is not limited to, the following:

(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP such as: permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO or DCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or <http://www.oregon.gov/DHS/aboutdhs/fraud/> as appropriate, consistent with 42 CFR 455.13;

(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060(4)

(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO or DCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;

(B) There shall be notification from the provider to the CCO or DCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO or DCO. Such notification shall be documented in the member's clinical record. The CCO or DCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The CCO or DCO shall contact the member either verbally or in writing if it is a severe problem to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO or DCO shall inform the member that their continued behavior may result in disenrollment from the CCO or DCO;

(D) The CCO or DCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;

(E) The CCO or DCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the CCO or DCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO or DCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The CCO or DCO shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence as the result of his or her special needs or disability, the CCO or DCO shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO or DCO shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others shall actually occur, and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A CCO or DCO-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

(v) Documentation of the CCO or DCO's rationale for concluding that the member's continued enrollment in the CCO or DCO seriously impairs the CCO's or DCO's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO or DCO shall attempt to locate another PCP on their panel who will accept the member as their patient. If needed, the CCO or DCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO or DCO's policies and shall be consistent with CCO or DCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO or DCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements in subsection (c), requests by the CCO or DCO for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56 the CCO or DCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO or DCO's staff so that it seriously impairs the CCO or DCO's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member will cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO or DCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;

(B) Providers shall immediately notify the CCO or DCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;

(C) The CCO or DCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;

(D) The CCO or DCO shall provide any additional information requested by the CAR, the Authority, or Department of Human Services assessment team;

(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO or DCO shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (2)(b)(C)(i) of this rule;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO or DCO shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others will actually occur, and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(F) Documentation shall exist that verifies the provider or CCO or DCO immediately reported the incident to law enforcement. The CCO or DCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures will not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the CCO or DCO's rationale for concluding that the member's continued enrollment in the CCO or DCO seriously impairs the CCO or DCO's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the CCO or DCO's CAR or a team of CARs who may request additional information from Ombudsman Services or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;

(B) In cases where the member is also enrolled in the CCO or DCO's Medicare Advantage plan, the CCO or DCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is insufficient documentation, the CAR shall notify the CCO or DCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the CCO or DCO of the decision within ten working days of receipt of sufficient documentation from the CCO or DCO;

(E) Written decisions shall be sent to the CCO or DCO within 15 working days from receipt of request and sufficient documentation from the CAR.

(5) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO or DCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will proceed unless the member requests continued enrollment pending a decision;

(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO or DCO;

(d) If no other CCO or DCO is available to the member, the member will be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO or DCO, the CCO or DCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO or DCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or DCO again requests disenrollment for cause, the request shall be referred to the Authority assessment team for review.

(6) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO or DCO and the member's care team.

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of member's right to file a complaint (as specified in OAR 410-141-3260 through 410-141-3266)

and to request an administrative hearing and the option to continue enrollment in the CCO or DCO pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) The disenrollment effective date will be ten calendar days after the disenrollment notice is sent to the member unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an Administrative Law Judge's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO or DCO;

(e) If no other CCO or DCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO or DCO, the CCO or DCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO or DCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or DCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.

(7) Other reasons for the CCO or DCO's requests for disenrollment may include the following:

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

(b) The member has surgery scheduled at the time their enrollment is effective with the CCO or DCO, the provider is not on the CCO or DCO's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO or DCO;

(d) Excluding the DCOs, if the CCO determines that the member or MHO member has Third Party Liability (TPL), the CCO will contact the Health Insurance Group (HIG) to request disenrollment;

(e) If a CCO or DCO has knowledge of a member's change of address, the CCO or DCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO or DCO if the member no longer resides in the CCO or DCO's service area. Members shall be disenrolled if out of the CCO or DCO's service area for more than three months unless previously arranged with the CCO or DCO. The effective date of

disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO or DCO;

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO or DCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from CCO or DCOs for members who have been taken into custody;

(g) The member is in a state psychiatric institution.

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

(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO or DCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the CCO or DCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO or DCO;

(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

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

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;

(b) The Authority may retroactively disenroll enrollment if the member has TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

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

Stats. Implemented: ORS 414.610 - 414.685