



# Oregon

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**Department of Human Services**

***Health Services***

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**TO:** Medical Service Providers

**FROM:** Joan Kapowich  
Program and Policy Manager

**SUBJECT:** Oregon Health Plan Rule Revision 4

**EFFECTIVE:** April 1, 2003

**Rule 410-141-0080** is revised to establish a process to disenroll repeat violent members from a managed care plan.

**Rules 410-141-0260, 410-141-0261 and 410-141-0264** are revised to correct minor punctuation errors.

**Rule 410-141-0520** is revised to explain how to find the latest Prioritized List.

The OHP Guide has not been updated at this time, but these rule changes will be incorporated in the next revision.

**Questions:** If you have billing questions, contact a Provider Services Representative, toll-free at 1-800-336-6016 or direct at (503) 378-3697.

**Additional information** for providers is available at OMAP's new Website:  
<http://www.dhs.state.or.us/policy/healthplan>

# 410-141-0080 Oregon Health Plan Disenrollment from Prepaid Health Plans

## (1) Client Requests for Disenrollment:

(a) All Oregon Health Plan (OHP) Client-initiated requests for Disenrollment from Prepaid Health Plans (PHP) must be initiated by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and OAR 461-110-0720, respectively. For OHP Clients who are not able to request Disenrollment on their own, the request may be initiated by the OHP Client's Representative;

(b) Primary person or Representative requests for Disenrollment shall be honored:

(A) After six months of OMAP Member's Enrollment without cause. The effective date of Disenrollment shall be the end of the month following the request for Disenrollment;

(B) Whenever OMAP Member eligibility is redetermined by Department of Human Services (DHS) and the Primary Person requests Disenrollment without cause. The effective date of Disenrollment shall be the end of the month following the date that the OMAP Member's eligibility is redetermined by DHS;

(C) OMAP Members who disenroll from a Medicare HMO shall also be Disenrolled from the corresponding PHP. The effective date of Disenrollment shall be the same date that their Medicare Health Maintenance Organization (HMO) disenrollment is effective;

(D) OMAP Members who are receiving Medicare and who are enrolled in a PHP that has a corresponding Medicare HMO may Disenroll from the PHP at any time if they also request disenrollment from the Medicare HMO. The effective date of Disenrollment from the PHP shall be the end of the month following the date of request for Disenrollment;

(E) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for Disenrollment. The determination shall be made within ten working days;

(ii) Examples of sufficient cause include but are not limited to:

(I) The OMAP Member moves out of the PHP's service area;

(II) It would be detrimental to the OMAP Member's health to remain enrolled in the PHP;

(III) The OMAP 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 delivery system;

(IV) Continuity of care that is not in conflict with any section of 410-141-0060 or 410-141-0080.

(F) If the following conditions are met:

(i) The Member is in the third trimester of her pregnancy and has just been determined eligible for OHP, or has just been redetermined eligible and was not enrolled in a Fully Capitated Health Plan (FCHP) within the past 3 months; and

(ii) The new FCHP 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 provider; and

(iii) The request to change plans or return to fee-for-service is made prior to the date of delivery.

(c) In addition to the Disenrollment constraints listed in (b), above, OMAP Member Disenrollment requests are subject to the following requirements:

(A) The OMAP Member shall join another PHP, unless the OMAP Member resides in a service area where Enrollment is voluntary, or the OMAP Member meets the exemptions to enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory service area is the plan from which the OMAP Member wishes to disenroll, the OMAP Member may not disenroll without cause;

(C) The effective date of Disenrollment shall be the end of the month in which Disenrollment was requested unless retroactive Disenrollment is approved by OMAP.

(2) Prepaid Health Plan requests for Disenrollment:

(a) Causes for Disenrollment:

(A) OMAP may Disenroll OMAP Members for cause when requested by the PHP subject to ADA requirements and approval by Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration (HCFA) if a Medicare Member disenrolled in a PHP's Medicare HMO. Examples of cause include, but are not limited to the following:

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

(ii) Member's behavior is disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the provider's ability to furnish services to either the Member or other members;

(iii) Member commits or threatens an act of physical violence directed at a medical provider or property, the provider's staff, or other patients, or the PHP's staff;

(iv) Member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts committed in any provider's or Prepaid Health Plan's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) (formerly Adult & Family Services) Fraud Unit as appropriate;

(v) Members who have been exempted from mandatory enrollment with a FCHP, due to the members eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060 (4) (b) (C);

(vi) Member fails to pay copayments for Covered Services as described in OAR 410-121-0153;

(vii) Continuous Disenrollment from Member's Service Area: A Member may be continuously disenrolled from their Service Area if:

(I) The member had been previously disenrolled in the same Service Area and for the reasons described in (2) (a) (A) (iii) above;

(II) The reason for continuous Disenrollment is the same as described in (2) (a) (A) (iii) above and the OMAP Member's behavior is such that a lay person would believe they are in danger, and any attempts to redirect the OMAP Member fail, OR, the OMAP Member is displaying or exhibiting threatening behavior with a weapon.

(B) OMAP Members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

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

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

(iv) Because the Member requests a hearing;

(v) Because the Member has been diagnosed with end-stage renal disease;

(vi) Because the Member exercises his/her option to make decisions regarding his/her medical care with which the plan disagrees.

(C) Requests by the PHP for Disenrollment of specific OMAP Members shall be submitted in writing to their PHP Coordinator for approval. The PHP must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below must be followed prior to requesting disenrollment of an OMAP Member (except in cases of threats or acts of physical violence, and fraudulent or illegal acts). In cases of threats or acts of physical violence, OMAP will consider an oral request for Disenrollment, with written documentation to follow: In cases of fraudulent or illegal acts, the PHP must submit written documentation for review by the PHP Coordinators:

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

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

(iii) The PHP shall provide individual education, counseling, and/or other intervention's in a serious effort to resolve the problem;

(iv) The PHP shall contact the Member's DHS caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of provider, caseworker, Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain a release of information to providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the Member's record;

(vi) If a Primary Care Provider (PCP) terminates the patient/provider relationship, 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 a release of information in order to share the information necessary for a new provider to evaluate if they can treat the Member. All terminations of provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP's or PCP's policies for commercial members.

(D) If the problem persists, the PHP may request disenrollment of the Member by submitting a written request to disenroll the Member to the plans' PHP Coordinator, with a copy to the Member's caseworker. Documentation with the request shall include the following:

(i) The reason the PHP is requesting disenrollment; a summary of the PHP's efforts to resolve the problem and other options attempted before requesting disenrollment;

(ii) Documentation should be objective, with as much specific details and direct quotes as possible when problems involve disruptive, unruly, abusive or threatening behaviors;

(iii) Where appropriate, background documentation including a description of Member's age, diagnosis, mental status (including their level of understanding of the problem and situation), functional status (their level of independence) and social support system;

(iv) Where appropriate, separate statements from PCPs, caseworker and other agencies, providers or individuals involved;

(v) If reason for the request is related to the OMAP Member's substance abuse treatment, the PHP shall notify the OHP Coordinator in the Office of Alcohol and Drug Abuse Services;

(vi) If Member is disabled, the following documentation shall also be submitted as appropriate:

(I) A written assessment of the relationship of the behavior to the disability including: 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;

(II) An interdisciplinary team review that includes a mental health professional and/or behavioral specialists to assess the behavior, its history, and previous history of efforts to manage behavior;

(III) If warranted, a clinical assessment that the behavior will not respond to reasonable clinical or social interventions;

(IV) Documentation of any accommodations that have been attempted;

(V) Any additional information or assessments requested by the PHP Coordinators.

(E) Requests will be reviewed according to the following process:

(i) If there is sufficient documentation, the request will be evaluated by a team of PHP Coordinators who may request additional information from Ombudsman, mental health or other agencies as needed;

(ii) If there is not sufficient documentation, the PHP Coordinator will notify the PHP what additional documentation is required before the request can be considered;

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

(iv) If the request is approved, the Disenrollment date is 30 days after the date of approval, except as provided in (F) and (G) below. The PHP must send the Member a letter within 14 days after the request was approved, with a copy to the Member's DHS caseworker and OMAP's Health Management Unit (HMU), except in cases where the Member is also enrolled in a PHP's Medicare HMO. The letter must give the disenrollment date, the reason for disenrollment, and the notice of Member's right to an Administrative Hearing;

(v) In cases where the Member is also enrolled in a PHP's Medicare HMO, the letter shall be sent after the approval by CMS and the date of disenrollment shall be the date of disenrollment as approved by CMS . If CMS does not approve the disenrollment, the Member shall not be disenrolled from the PHP's OHP Plan;

(vi) If Member requests a hearing, the Member will continue to be Disenrolled until a hearing decision reversing that disenrollment has been mailed to the Member and the PHP;

(vii) The PHP Coordinators will determine when enrollment in another PHP or with a PCCM is appropriate. PHP Coordinator will contact Member's DHS caseworker to arrange enrollment;

(viii) When the disenrollment date has been determined, HMU sends a letter to the Member with a copy to the Member's DHS caseworker and the PHP. The letter shall inform Member of the requirement to be enrolled in another PHP.

(F) If the PHP Coordinators approve a PHP's request for Disenrollment because the OMAP Member threatens or commits an act of physical violence directed at a medical provider, the provider's staff, or other patients, the following procedures shall apply:

(i) OMAP shall inform the Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) All OMAP Members in the OMAP Member's benefit group, as defined in OAR 461-110-0720, may be Disenrolled if the PHP requests;

(iv) OMAP may require the OMAP Member and/or the benefit group to obtain services from fee-for-service providers or a PCCM until such time as they can be enrolled in another PHP;

(v) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(G) If the PHP Coordinator approves the PHP's request for Disenrollment because the OMAP Member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following procedures shall apply:

(i) The PHP shall inform the OMAP Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(iv) If an OMAP Member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the plan's PHP Coordinator. A Member may not be 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 is again disenrolled for cause, the disenrollment will be reviewed by DHS for further action.

(b) Other Reasons for the PHP's Requests for Disenrollment include the following:

(A) If the OMAP Member is enrolled in the FCHP or MHO on the same day the Member is admitted to the hospital, the FCHP or MHO 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 the date of enrollment shall be 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 Cost Plan and was in a hospice 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 DCO, the PHP determines that the OMAP Member has a third party insurer. If after contacting The Health Insurance Group, the Disenrollment is not effective the following month, PHP may contact HMU to request Disenrollment;

(F) If a PHP has knowledge of an OMAP Member's change of address, PHP shall notify DHS. DHS will verify the address information and disenroll the Member from the plan, 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 (3) months, unless previously arranged with the PHP. The effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment;

(G) The OMAP Member is an inmate who is serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. 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. PHP is responsible for identifying said clients and providing sufficient proof of incarceration to the Health Management Unit for review of the disenrollment request. OMAP will approve requests for disenrollment from PHPs for Members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHP is responsible for inpatient services only during the time an OMAP Member was an inmate;

(H) The Member is in a state psychiatric institution.

(3) OMAP Initiated Disenrollments:

(a) OMAP may initiate and disenroll OMAP Members as follows:

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

(B) If the OMAP Member moves out of the PHP's service area(s), the effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment;

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

(D) If the OMAP Member dies, the effective date of Disenrollment shall be the end of the month following the date of death;

(E) When a non-Medicare Contracting PHP is assumed by another PHP that is a Medicare HMO, OMAP Members with Medicare shall be disenrolled from the existing PHP. The effective date of Disenrollment shall be the day prior to the month the new PHP assumes the existing PHP.

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

(c) OMAP shall inform the Members of the Disenrollment decision in writing, including the right to request an Administrative Hearing. Oregon Health Plan Members may request an OMAP hearing if they dispute a disenrollment decision by OMAP;

(d) If Member requests a hearing, the Member will continue to be disenrolled until a hearing decision reversing that Disenrollment has been mailed to the Member.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

## 410-141-0260 Oregon Health Plan Prepaid Health Plan Complaint Procedures

1) This rule will apply to all PHPs except MHOs. MHOs shall abide by the complaint requirements as stated in the MHO Agreement.

(2) FCHPs, DCOs, and CDOs shall have written policies and procedures that ensure that they meet the requirements of sections OAR 410-141-0260 to OAR 410-141-0266.

(3) FCHPs, DCOs, and CDOs shall keep all information concerning an OMAP member's Complaint confidential as specified in OAR 410-141-0261.

(4) FCHPs, DCOs, and CDOs must have a written procedure to handle complaints from OMAP members or their representatives. At a minimum, the procedure must meet the requirements of OAR 410-141-0261.

(5) FCHPs, DCOs, and CDOs shall afford OMAP Members the full use of the Complaint procedures, and shall cooperate if the OMAP Member decides to pursue a remedy through the Administrative Hearing process.

(6) Hearing requests made outside of the Complaint process or without previous use of the Complaint process shall be reviewed by the FCHP, DCO, or CDO through the FCHP's, DCO's, or CDO's Complaint process upon notification by OMAP as provided for in OAR 410-141-0264.

(7) Under no circumstances may FCHP, DCO, or CDO discourage an OMAP Member's use of the Administrative Hearing process. The FCHP, DCO, or CDO may, however, explain to the OMAP Member the potential benefits of using the Complaint procedure.

(8) Neither implementation of an OMAP hearing decision nor an OMAP Member's request for a hearing may be a basis for a request by the FCHP, DCO, or CDO for Disenrollment of an OMAP Member.

(9) FCHPs, CDOs, and CDOs shall make available a supply of blank Complaint forms (OMAP 3001) in all plan administrative offices and in those medical/dental offices where staff have been designated by the FCHP, DCO, or CDO to respond to Complaints.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

## 410-141-0261 Complaint Procedures

(1) FCHPs, DCOs, and CDOs shall have written procedures for the receipt, disposition and documentation of all Complaints from OMAP Members. The FCHPs', DCOs', and CDOs' written procedures for handling complaints, shall, at a minimum:

(a) Address how contractor will accept, process and respond to all Complaints from OMAP Members or their Representatives;

(b) Address the resolution of all Complaints which OMAP Members identify as needing resolution;

(c) Describe how the FCHP, DCO, or CDO informs OMAP Members, both orally and in writing, about FCHP's, DCO's, or CDO's Complaint procedures. Information provided to the member shall include at least:

(A) Written material describing the Complaint process; and

(B) Assurance in all written, oral, and posted material of OMAP Member confidentiality in the Complaint process.

(d) Designate the FCHP, DCO, or CDO staff member(s) or a designee who will be responsible for receiving, processing, directing, and responding to Complaints;

(e) Ensure that clients who indicate dissatisfaction or concern are informed of their right to file a Complaint and how to do so;

(f) Include a requirement for a log to be maintained by the FCHP, DCO, or CDO that is in compliance with OAR 410-141-0266.

(2) The FCHP, DCO, or CDO shall assure members that complaints are handled in confidence and shall safeguard the client's right to confidentiality of information about the Complaint as follows:

(a) FCHPs, DCOs, and CDOs shall, implement and monitor written policies and procedures that ensure that all information concerning an OMAP Member's Complaint is kept confidential, except that OMAP has a right to this information without a signed release from the OMAP Member;

(b) If an OMAP Member makes a Complaint or files a hearing request, and wishes the Complaint to be resolved, FCHPs, DCOs, and CDOs shall ask the OMAP Member to consent verbally to the release of information regarding the Complaint to individuals who are directly involved in the Complaint:

(A) Before any information related to the Complaint is released, the FCHP, DCO, or CDO shall have a release of information documented in the Complaint file;

(B) FCHPs, DCOs, and CDOs shall inform the OMAP Member if failure to consent may make it impossible to resolve the Complaint;

(C) FCHPs' DCOs' and CDOs' written procedures shall describe how complaints will be resolved and reviewed should OMAP Member decline to provide a release;

(D) An OMAP Member's consent to release information related to the Complaint does not constitute consent to release medical information unrelated to the Complaint.

(3) The FCHP, DCO, or CDO shall assure that a member's expression of dissatisfaction, or Complaint is recognized by FCHP, DCO, or CDO staff as follows:

(a) The expression may be in whatever form of communication or language that is used by the OMAP Member or the Member's Representative:

(A) An OMAP Member may relate any incident or concern to a practitioner or other staff person by indicating or expressing dissatisfaction or concern or by stating this is a Complaint that needs resolution;

(B) If the OMAP Member indicates dissatisfaction or concern, the practitioner or staff person shall advise the OMAP Member that he or she may make a Complaint using the FCHP's, DCO's, or CDO's Complaint process.

(b) A Complaint requires resolution as follows:

(A) The OMAP Member or the Member's Representative identifies the expression of dissatisfaction as a Complaint which must be addressed by the FCHP, DCO, or CDO;

(B) The OMAP Member or Member's Representative's intent is unclear to the FCHP, DCO, or CDO or the FCHP's, DCO's, or CDO's designee. The FCHP, DCO, or CDO or the FCHP's, DCO's, or CDO's designee shall confirm that the expression of dissatisfaction is a Complaint in need of resolution by asking the OMAP Member or the Member's Representative if the expression of dissatisfaction is something that needs resolution;

(C) Complaints may also be termed concerns, problems, or issues by the OMAP Member or the Member's Representative and may or may not be identified by the Member or the Member's Representative as needing resolution.

(4) The FCHPs', DCOs', and CDOs' procedures shall provide for the resolution of complaints as follows:

(a) The practitioner or staff person shall either resolve the Complaint and communicate the Complaint and its resolution to the FCHP's, DCO's, CDO's; or direct the OMAP Member to the FCHP's, DCO's, or CDO's staff person designated

for receiving Complaints, as identified in FCHP's, DCO's, or CDO's OMAP Member Handbook;

(b) If an OMAP Member makes a Complaint to the FCHP's, DCO's, or CDO's staff person designated for receiving Complaints, the staff person shall notify the OMAP Member that the OMAP Member has the right to make a Complaint either orally or in writing;

(c) If the OMAP Member does not wish to attempt to resolve the Complaint through the use of the FCHP's, DCO's, or CDO's internal Complaint procedure, the staff person shall notify the OMAP Member that the member has the right to seek resolution through another process within the plan or through a state process, such as the Administrative Hearing process or OMAP Ombudsman;

(d) If the OMAP Member chooses to pursue the Complaint orally or in writing through FCHPs', DCOs', and CDOs' internal Complaint procedure, shall within 5 working days from the date either:

(A) Make a decision on the Complaint; or

(B) Notify the OMAP Member in writing that a delay in FCHP's, DCO's, or CDO's decision of up to 30 calendar days from the date the Complaint was received by the FCHP, DCO, or CDO is necessary to resolve the Complaint. Contractor shall specify the reasons the additional time is necessary.

(5) Complaints concerning denial of service or service coverage shall be handled as Complaints as described in this section. In addition, FCHPs, DCOs, or CDOs shall immediately issue notice and provide OMAP Members with a notice of Hearing Rights (OMAP 3030) and an Administrative Hearing Request (AFS 443) as described in OAR 410-141-0263, upon receipt of a Complaint concerning denial of service or service coverage.

(6) The FCHPs', DCOs', and CDOs' staff person, who is designated to receive complaints, shall begin to establish the facts concerning the Complaint, upon receipt of the Complaint regardless of whether the OMAP Member seeks an Administrative Hearing and/or elects the Complaint process.

(7) FCHPs', DCOs', and CDOs' decision shall be communicated to the OMAP Member orally or in writing no later than 30 calendar days from the date of receipt of the Complaint:

(a) An oral decision shall address each aspect of the client's Complaint and explain the reason for the contractor's decision. The oral decision shall include informing the OMAP Member of his/her rights to an Administrative Hearing;

(b) A written decision must be made if the Complaint was received in writing, or if the Complaint involves a denial of services or service coverage:

(A) The written decision on the Complaint shall review each element of the OMAP Member's Complaint and address each of those concerns specifically, including the reasons for the FCHP's, DCO's, or CDO's decision;

(B) The written decision shall have both the Notice of Hearing Rights (OMAP 3030) and the AFS 443, Hearing Request, attached;

(C) A written decision which involves denial of service or service coverage must conform to the requirements for notice in OAR 410-141-0263.

(8) All Complaints made to the FCHP's, DCO's, or CDO's staff person designated to receive Complaints shall be entered into a log and addressed in the context of Quality Assurance activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(9) All Complaints that the member chooses to resolve through another process, and that the FCHP, DCO, or CDO is notified of, shall be noted in the Complaint log.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

## 410-141-0264 Administrative Hearings

(1) Individuals who are or were OMAP Members at the time an action is taken are entitled to an Administrative Hearing by OMAP regarding the action by an FCHP, DCO, or CDO to deny services, payment of a claim, or to terminate, discontinue or reduce a course of treatment. OMAP Members are also entitled to an Administrative Hearing for issues related to their eligibility for OHP benefits, or issues related to enrollment in FCHPs, DCOs, or CDOs. Client hearings are governed by OAR 410-121-1860 and following:

(a) A written hearing request must be received by the Hearings Unit at OMAP not later than the 45th day following the date of the Notice of Action or written decision regarding a complaint;

(b) If the action involves a Notice of Action or decision concerning a complaint that involved continuation of services, and the OMAP Member or OMAP Member's Representative wishes to have services continued while the hearing issue is being resolved, the OMAP Member or OMAP Member's Representative must request a hearing before the effective date of the intended action or within 10 calendar days after the notice of action or written complaint decision was mailed or given to the OMAP Member or OMAP Member's Representative.

(2) The OMAP Representative shall review the Administrative Hearing Requests, documentation related to the Hearing issue, and computer records to determine whether the claimant or the person for whom the request is being made is or was an OMAP Member at the time the action was taken, whether the hearing request was timely (requested within 45 calendar days of the Notice of Action, or the decision about a complaint) and whether continuation of benefits or services has been requested.

(3) The hearing request (AFS 443) shall be referred to the Central Hearings Panel and a hearing officer requested. OMAP Member hearings are governed by OAR 410-120-1860 and following, except to the extent OMAP rules apply.

(4) A final order must be issued or the case otherwise resolved by OMAP not later than 90 days following OMAP's receipt of the request for hearing. Delay due to a postponement or continuance granted at the OMAP Member or OMAP Member Representative's request or with the consent of the OMAP Member or the OMAP Member's Representative shall not be counted in computing the time limit. The final order is the final decision of OMAP.

(5) FCHPs, DCOs, and CDOs shall immediately transmit to OMAP any hearing request submitted on behalf of a client. (6) If an Administrative Hearing is requested by an OMAP Member, the FCHP, DCO, or CDO shall cooperate in the hearing process and shall make available, as determined necessary by OMAP, all persons with relevant information, including the staff person who attempted

resolution of the complaint. The FCHP, DCO, or CDO shall also provide all pertinent files and medical or dental records, as well as the results of the review by the FCHP, DCO, or CDO of the hearing request and any attempts at resolution by the contractor.

(7) If the OMAP Member files a request for an Administrative Hearing, OMAP shall immediately notify the FCHP, DCO, or CDO. The FCHP, DCO, or CDO shall review the Hearing Request as a Complaint as described below.

(8) OMAP Members may request a delay in the Administrative Hearing in writing. This delay shall not relieve the FCHP, DCO, or CDO of resolving the complaint that was referred to them by the Hearings Representative within 30 days.

(9) FCHPs, DCOs, and CDOs shall review the Hearing Request, which has not been previously received or reviewed as a complaint, using the FCHP's, DCO's, or CDO's Complaint process as follows:

(a) The Complaint shall be reviewed immediately and shall be resolved, if possible, within 30 days of receipt of the request for hearing in OMAP;

(b) The FCHP's, DCO's, or CDO's decision shall be in writing and shall be provided to OMAP, and to the OMAP Member;

(c) If the Complaint is not resolved within 30 days, or the member does not accept resolution proposed by the FCHP, DCO, or CDO on the hearing request, the FCHP, DCO, or CDO shall provide the OMAP Hearings Representative with all pertinent material and documentation within 30 days from the date of the transmittal of the request for hearing from OMAP. Complaints are defined in OAR 410-141-0000, Definitions.

(10) If the OMAP Member chooses to use the FCHP's, DCO's, or CDO's Complaint procedure as well as the Administrative Hearing process, the FCHP, DCO, or CDO shall ensure that the Complaint procedure is completed within 30 days of receipt of the Complaint, and the records sent to the OMAP Hearings Unit by the 30th day.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

## 410-141-0520 Prioritized List of Health Services

(1) The Prioritized List of Health Services (Prioritized List) is the Oregon Health Services Commission's (HSC) listing of physical health services with "expanded definitions" of Ancillary Services and Preventive Services, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The most current list, dated October 1, 2002, is available on the HSC website ([http://www.ohpr.state.or.us/hsc/index\\_hsc.htm](http://www.ohpr.state.or.us/hsc/index_hsc.htm)) or, for a hardcopy, contact the Office of Health Policy and Research. This rule references the Prioritized List, updated with April 1, 2003, revisions, available on the HSC website.

(2) Certain Mental Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP) or authorized Fully Capitated Health Plan (FCHP). These codes are identified on their own Mental Health (MH) section of the appropriate lines on the Prioritized List of Health Services.

(3) Chemical dependency (CD) services are covered for eligible OHP clients when provided by an FCHP or by a provider who has a letter of approval from the Office of Mental Health and Addiction Services and approval to bill Medicaid for CD services. These codes are identified on the Chemical Dependency (CD) section of line 188.

(4) The first 558 lines of the Prioritized List of Services are currently funded and are covered for payment by OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065