DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Oregon Health Plan (OHP) Program Rulebook

Includes:

1) Current Update Information (changes since last update)

2) Table of Contents

3) Complete set of OHP Program Administrative Rules

OHP Program Rulebook

Update Information

for

October 14, 2005

OMAP updated the OHP Program Rulebook as follows:

OMAP temporarily amended 410-141- 0520 to reflect Centers for Medicare and Medicaid Services (CMS) approval of technical changes made, effective April 1, 2005 and October 1, 2005, to the October 1, 2003 Prioritized List of Health Services.

Due to these CMS approved technical revisions, 410-141-0520 is retroactively effective April 1, 2005 and October 1, 2005. The October 1, 2005 technical changes are effective for October 1 through December 31, 2005.

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

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 141

OREGON HEALTH PLAN

410-141-0000 Definitions

410-141-0010 Screening and Selection Procedures for Managed Care Services by Prepaid Health Plans

410-141-0020 Administration of Oregon Health Plan Regulation and Rule Precedence

410-141-0060 Oregon Health Plan Managed Care Enrollment Requirements

410-141-0070 Oregon Health Plan Fully Capitated Health Plan (FCHP) Pharmaceutical Drug List Requirements

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

410-141-0085 Oregon Health Plan Disenrollment from Primary Care Managers

410-141-0110 Oregon Health Plan Prepaid Health Plan Member Satisfaction Survey

410-141-0115 Oregon Health Plan Primary Care Manager Member Satisfaction Survey

410-141-0120 Oregon Health Plan Prepaid Health Plan Provision of Health Care Services

410-141-0140 Oregon Health Plan (OHP) Prepaid Health Plan (PHP) Emergency and Urgent Care Services

410-141-0160 Oregon Health Plan Prepaid Health Plan (PHP) Coordination and Continuity of Care

410-141-0180 Oregon Health Plan Prepaid Health Plan Record Keeping

410-141-0200 Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System

410-141-0220 Oregon Health Plan Prepaid Health Plan Accessibility

410-141-0260 Oregon Health Plan Prepaid Health Plan Complaint or Grievance and Appeal Procedures

410-141-0261 PHP Complaint Procedures

410-141-0262 PHP's Appeal Procedures

410-141-0263 Notice of Action by a Prepaid Health Plan

410-141-0264 Administrative Hearings

410-141-0265 Request for Expedited Appeal or Expedited Administrative Hearing

410-141-0266 The PHP’s Responsibility for Documentation and Quality Improvement Review of the Grievance System

410-141-0270 Oregon Health Plan Marketing Requirements

410-141-0280 Oregon Health Plan Prepaid Health Plan Informational Requirements

410-141-0300 Oregon Health Plan Prepaid Health Plan Member Education

410-141-0320 Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

410-141-0340 Oregon Health Plan Prepaid Health Plan Financial Solvency

410-141-0400 Oregon Health Plan Prepaid Health Plan Case Management Services

410-141-0405 Oregon Health Plan Fully Capitated Health Plan Exceptional Needs Care Coordination (ENCC)

410-141-0407 Oregon Health Plan Ombudsman Services

410-141-0410 Oregon Health Plan Primary Care Managers

410-141-0420 Oregon Health Plan Prepaid Health Plan Billing and Payment Under the Oregon Health Plan

410-141-0440 Prepaid Health Plan Hospital Contract Dispute Resolution

410-141-0480 Oregon Health Plan Benefit Package of Covered Services

410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients and or OMAP Members

410-141-0520 Prioritized List of Health Services

410-141-0660 Oregon Health Plan Primary Care Manager (PCM) Provision of Health Care Services

410-141-0680 Oregon Health Plan Primary Care Manager Emergency and Urgent Care Medical Services

410-141-0700 OHP PCM Continuity of Care

410-141-0720 Oregon Health Plan Primary Care Manager Medical Record Keeping

410-141-0760 Oregon Health Plan Primary Care Managers Accessibility

410-141-0780 Oregon Health Plan Primary Care Manager(PCM) Complaint Procedures

410-141-0800 Oregon Health Plan Primary Care Manager (PCM) Informational Requirements

410-141-0820 Oregon Health Plan Primary Care Manager (PCM) Member Education

410-141-0840 Oregon Health Plan Primary Care Manager (PCM) Member Rights And Responsibilities

410-141-0860 Oregon Health Plan Primary Care Manager Provider Qualification and Enrollment

410-141-0000 Definitions

(1) Action – In the case of a Prepaid Health Plan (PHP):

(a) The denial or limited authorization of a requested covered 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 OMAP;

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

(f) For an OMAP Member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) Service Area, the denial of a request to obtain covered services outside of the FCHP or MHO's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(2) Administrative Hearing -- A DHS hearing related to an Action, including a denial, reduction, or termination of benefits, which is held when requested by the OHP Client or OMAP Member. A hearing may also be held when requested by an OHP Client or OMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(3) Advance Directive -- A form that allows a person to have another person make health care decisions when he/she cannot make the decision and tells a doctor that the person does not want any life sustaining help if he/she is near death.

(4) Aged – Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities for receipt of medical assistance because of age.

(5) Americans with Disabilities Act (ADA) -- Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable

accommodations be made in employment, service delivery, and facility accessibility.

(6) Alternative Care Settings -- Sites or groups of practitioners, which provide care to OMAP Members under contract with the PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, outpatient surgicenters.

(7) Ancillary Services -- Those medical services under the Oregon Health Plan not identified in the definition of a Condition/Treatment Pair under the OHP Benefit Package, but Medically Appropriate to support a service covered under the OHP benefit package. A list of ancillary services and limitations is identified in OAR 410-141-0520, Prioritized List of Health Services, or specified in the Ancillary Services Criteria Guide.

(8) Appeal – A request for review of an “Action” as defined in this section.

(9) Automated Information System (AIS) -- A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program.

(10) Blind – Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(11) Capitated Services -- Those Covered Services that a PHP or Primary Care Manager agrees to provide for a Capitation Payment under an OMAP Oregon Health Plan contract or agreement.

(12) Capitation Payment:

(a) Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP;

(b) Monthly prepayment to a Primary Care Manager to provide Primary Care Management Services for an OHP Client who is enrolled with the PCM. Payment is made on a per OHP Client, per month basis.

(13) Centers for Medicare and Medicaid Services (CMS). The federal agency under the Department of Health and Human Services, responsible for approving the waiver request to operate the Oregon Health Plan Medicaid Demonstration Project.

(14) CFR- Code of Federal Regulations.

(15) Chemical Dependency Services -- Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(16) Chemical Dependency Organization (CDO) -- a Prepaid Health Plan that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the Oregon Health Plan. All chemical dependency services covered under the Oregon Health Plan are covered as Capitated Services by the CDO.

(17) Chemical Dependency Services -- Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(18) Children's Health Insurance Program (CHIP) -- A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by the Department of Human Services, Office of Medical Assistance Programs (see Medical Assistance).

(19) Children Receiving CAF Child Welfare or OYA Services -- Individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of Children, Adults and Families Services, Department of Human Services or Oregon Youth Authority who are in placement outside of their homes.

(20) Claim — (1) A bill for services, (2) a line item of a service, or (3) all services for one recipient within a bill.

(21) Clinical Record -- The Clinical Record includes the medical, dental, or mental health records of an OHP Client or OMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the ENCC, Complaint and Disenrollment for cause records, which may reside in the PHP's administrative offices.

(22) Cold Call Marketing — Any unsolicited personal contact by a PHP with a Potential Member for the purpose of Marketing as defined in this rule.

(23) Comfort Care -- The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to make it possible for an individual with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for disabled infants with life-threatening conditions that are not covered under Condition/Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 -- Patient Self-Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(24) Community Mental Health Program (CMHP) -- The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the DHS Office of Mental Health and Addiction Services.

(25) Comorbid Condition -- A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient.

(26) Complaint -- An OMAP Member's or OMAP Member's Representative's expression of dissatisfaction to a PHP or Participating Provider about any matter other than an Action, as "Action" is defined in this Section.

(27) Community Standard -- Typical expectations for access to the health care delivery system in the OMAP Member's or PCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, OMAP requires that the health care delivery system available to OMAP Members in Prepaid Health Plans and to PCM Members with Primary Care Managers take into consideration the Community Standard and be adequate to meet the needs of OMAP and PCM Members.

(28) Condition/Treatment Pair -- Diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9 CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the DHS Office of Mental Health and Addiction Services Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

(29) Continuing Treatment Benefit -- A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to the OHP Benefit Package of covered services and that treatment is not covered under the OHP Benefit Package of covered services.

(30) Co-payment -- The portion of a covered service that an OMAP Member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.

(31) Contract -- The contract between the State of Oregon, acting by and through its Department of Human Services (DHS), Office of Medical Assistance Programs (OMAP) and a Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Physician Care Organization (PCO), or a Chemical Dependency Organization (CDO), or between the Office of Mental Health and Addiction Services (OMHAS) and a Mental Health Organization (MHO) for the provision of covered services to eligible OMAP Members for a Capitation Payment. Also referred to as a Service Agreement.

(32) Covered Services -- are Medically Appropriate health services that are funded by the Legislature and described in ORS 414.705 to 414.750; OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System; OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services; OAR 410-141-0520, Prioritized List of Health Services; and OAR 410-141-0480, Oregon Health Plan Plus Benefit Package of Covered Services; except as excluded or limited under OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients and OAR 410 Division 120.

(33) Dentally Appropriate -- Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the Oregon Health Plan Member or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to an OMAP Member.

(34) Dental Care Organization (DCO) -- A Prepaid Health Plan that provides and coordinates capitated dental services. All dental services covered under the Oregon Health Plan are covered as Capitated Services

by the DCO; no dental services are paid by OMAP on a fee-for-service basis for Oregon Health Plan Clients enrolled with a DCO provider.

(35) Dental Case Management Services -- Services provided to ensure that eligible OMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the Member plus the development and implementation of a plan to ensure that eligible OMAP Members obtain Capitated Services.

(36) Dental Emergency Services -- Dental services may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(37) Dental Practitioner -- A practitioner who provides dental services to OMAP Members under an agreement with a DCO, or is a Fee-For-Service Health Care Practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(38) Department of Human Services (DHS) -- DHS is made up of three program areas: Children, Adults and Families; Health Services; and Seniors and People with Disabilities. They are supported by the Director's Office; Administrative Services; and Finance and Policy Analysis. The Office of Medical Assistance Programs and the Office of Mental Health and Addiction Services are part of the Health Services Cluster.

(39) Diagnostic Services -- Those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(40) Disabled -- Individuals who meet eligibility criteria established by the DHS Seniors and People with Disabilities for receipt of Medical Assistance because of a disability.

(41) Disenrollment -- The act of discharging an Oregon Health Plan Client from a Prepaid Health Plan's or Primary Care Manager's responsibility. After the effective date of Disenrollment an Oregon Health Plan Client is no longer required to obtain Capitated Services from the Prepaid Health Plan or Primary Care Manager, nor be referred by the Prepaid Health Plan for

Medical Case Managed Services or by the Primary Care Manager for PCM Case Managed Services.

(42) Dual Eligible -- OHP Clients who are receiving both Medicaid and Medicare benefits.

(43) Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An “Emergency Medical Condition” is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(44) Emergency Services -- Covered Services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(45) Enrollment -- Oregon Health Plan Clients, subject to OAR 410-141-0060 -- Oregon Health Plan Managed Care Enrollment Requirements, become OMAP Members of a Prepaid Health Plan or PCM Members of a Primary Care Manager that contracts with OMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the OMAP Member must obtain or be referred by the PHP for all Capitated Services and referred by the PHP for all Medical Case Managed Services subsequent to the effective date of Enrollment. An Oregon Health Plan Client's Enrollment with a Primary Care Manager indicates that the PCM Member must obtain or be referred by the Primary Care Manager for preventive and primary care and referred by the Primary Care Manager for all PCM Case Managed Services subsequent to the effective date of Enrollment.

(46) Enrollment Area -- Client enrollment is based on the client's residential address and zip code. The address is automatically assigned a county

code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the DHS worker that Plan(s) are in the area.

(47) Enrollment Year -- A twelve-month period beginning the first day of the month of Enrollment of the Oregon Health Plan Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of Oregon Health Plan Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(48) End Stage Renal Disease (ESRD) -- End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.

(49) Exceptional Needs Care Coordination (ENCC) -- A specialized case management service provided by Fully Capitated Health Plans to OMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405, Oregon Health Plan Prepaid Health Plan Exceptional Needs Care Coordination (ENCC). ENCC includes:

(a) Early identification of those OMAP Members who are Aged, Blind or Disabled who have disabilities or 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.

(50) Family Health Insurance Assistance Program (FHIAP) -- A program in which the State subsidizes premiums in the commercial market for

uninsured individuals and families with income below 185% of the FPL. FHIAP is funded with federal and states funds through either Title XIX, XXI or both.

(51) Family Planning Services -- Services for clients of childbearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(52) Fee-for-Service Health Care Providers -- Health care providers who bill for each service provided and are paid by OMAP for services as described in OMAP provider rules. Certain services are covered but are not provided by Prepaid Health Plans or by Primary Care Managers. The client may seek such services from an appropriate Fee-For-Service provider. Primary Care Managers provide primary care services on a fee-for-service basis and might also refer PCM Members to specialists and other providers for fee-for-service care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP Clients in these areas will receive all services from Fee-For-Service providers.

(53) FPL – Federal Poverty Level.

(54) Free-Standing Mental Health Organization (MHO) -- The single MHO in each county that provides only mental health services and is not affiliated with a Fully Capitated Health Plan for that service area. In most cases this "carve-out" MHO is a county Community Mental Health Program or a consortium of Community Mental Health Programs, but may be a private behavioral health care company.

(55) Fully Capitated Health Plan (FCHP) -- Prepaid Health Plans that contract with OMAP to provide capitated services under the Oregon Health Plan. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(56) Grievance System–The overall system that includes Complaints and Appeals handled at the PHP level and access to the state fair hearing process. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the OMAP Member’s rights.)

(57) Health Care Professionals -- Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Licensed Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of OMAP members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

(58) Health Insurance Portability and Accountability Act (HIPAA) of 1996 -- HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(59) Health Maintenance Unit (HMU) -- The OMAP unit responsible for adjustments to enrollments, retroactive Disenrollment and enrollment of newborns.

(60) Health Plan New/Noncategorical Client (HPN) -- A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an Oregon Health Plan Client.

(61) Health Services Commission -- An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.

(62) Hospice Services -- A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

(63) Hospital Hold -- A hospital hold is a process that allows a hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP, if clients become eligible through a hospital hold process and are placed in the Adults/Couples category.

(64) Line Items -- Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the Oregon Health Plan Medicaid Demonstration Project.

(65) Local and Regional Allied Agencies include the following: local Mental Health Authority; Community Mental Health Programs; local DHS offices; Commission on Children and Families; Oregon Youth Authority; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

(66) Marketing — Any communication from a PHP to a Medicaid recipient who is not enrolled in that PHP which can reasonably be interpreted as an attempt to influence the recipient:

(a) To enroll in that particular PHP;

(b)To either Disenroll or not to enroll with another PHP.

(67) Marketing Materials — Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for Marketing as defined in this rule.

(68) Medicaid -- A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department of Human Services.

(69) Medical Assistance Program -- A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Office of Medical Assistance Programs (OMAP), of the Department of Human Services. Coordination of the Medical Assistance Program is the responsibility of the Office of Medical Assistance Programs.

(70) Medical Care Identification -- The preferred term for what is commonly called the "medical card." It is a letter-sized document issued monthly to Medical Assistance Program clients to verify their eligibility for services and enrollment in PHPs.

(71) Medical Case Management Services — Services provided to ensure that OMAP Members obtain health care services necessary to maintain physical and emotional development and health. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.

(72) Medically Appropriate -- Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an Oregon Health Plan Client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an OMAP Member or PCM Member in the PHP's or Primary Care Manager's judgment.

(73) Medicare -- The federal health insurance program for the Aged and Disabled administered by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act.

(74) Medicare HMO -- A capitated health plan that meets specific referralines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(75) Mental Health Assessment -- The determination of an OMAP Member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a Member's mental status, psychosocial history and current problems through interview, observation and testing.

(76) Mental Health Case Management -- Services provided to OMAP Members who require assistance to ensure access to benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the OMAP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring OMAP Members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.

(77) Mental Health Organization (MHO) -- A Prepaid Health Plan under contract with the Office of Mental Health and Addiction Services that provides mental health services as capitated services under the Oregon Health Plan. MHOs can be Fully Capitated Health Plans, community mental health programs or private behavioral organizations or combinations thereof.

(78) Non-Capitated Services -- Those OHP-covered services that are paid for on a fee-for-service basis and for which a capitation payment has not been made to a PHP.

(79) Non-covered services -- Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered

under the Oregon Health Plan. Non-covered services for the Oregon Health Plan are identified in:

(a) OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual provider administrative rules.

(80) Non-Participating Provider -- A provider who does not have a contractual relationship with the Prepaid Health Plan, i.e. is not on their panel of providers.

(81) Office of Medical Assistance Programs (OMAP) -- The Office of the Department of Human Services responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and the Children's Health Insurance Program (CHIP). OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays OMAP providers.

(82) Office of Mental Health and Addiction Services (OMHAS) -- The Department of Human Services office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.

(83) OMAP Member -- An Oregon Health Plan Client enrolled with a Prepaid Health Plan.

(84) Ombudsman Services -- Services provided by DHS to Aged, Blind and Disabled Oregon Health Plan Clients by DHS Ombudsman Staff who may serve as the Oregon Health Plan Client's advocate whenever the Oregon Health Plan Client, Representative, a physician or other medical personnel, or other personal advocate serving the Oregon Health Plan Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the Oregon Health Plan. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about Oregon Health Plan systems.

(85) Oregon Health Plan (OHP) -- The Medicaid demonstration project that expands Medicaid eligibility to eligible Oregon Health Plan Clients. The Oregon Health Plan relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(86) Oregon Health Plan (OHP) Plus Benefit Package -- A benefit package available to eligible Oregon Health Plan clients as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-120-0520, Prioritized List of Health Services.

(87) Oregon Health Plan (OHP) Standard Benefit Package -- A benefit package available to eligible Oregon Health Plan clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-141-0520, Prioritized List of Health Services.

(88) Oregon Health Plan Client -- An individual found eligible by DHS to receive services under the Oregon Health Plan. Clients in the following OHP categories eligible to enroll in PHPs defined as follows:

(a) Temporary Assistance to Needy Families (TANF) recipients are eligible with income under current Children, Adults and Families (CAF) eligibility rules;

(b) Children's Health Insurance Program (CHIP) -- children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) Adults under 100% Federal Poverty Level (FPL) are OHP recipients who are pregnant women with income under 100% of FPL as defined by CAF;

(d) PLM Adults over 100% FPL are OHP recipients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% FPL and do not meet one of the other eligibility classifications;

(h) OHP Adults and Couples are OHP Clients aged 19 or over and not Medicare eligible, with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP Families are OHP Clients, aged 19 or over and not Medicare eligible, with income below 100% of FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare are OHP Clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare are OHP Clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare are OHP Clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP recipients who are children with medical eligibility determined by Children, Adults and Families or the Oregon Youth Authority receiving OHP under ORS 414.025(2)(f), (l), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of the Children, Adults and Families or the Oregon Youth Authority who are in placement outside of their homes.

(89) Oregon Youth Authority -- The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(90) Participating Provider -- An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to OMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

(91) PCM Case Managed Services include the following: Preventive Services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, Community Mental Health Programs, Mental Health Organizations; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(92) PCM Member -- An Oregon Health Plan Client enrolled with a Primary Care Manager.

(93) PHP Coordinator – the DHS OMAP employee designated by OMAP as the liaison between OMAP and the PHP.

(94) Physician Care Organization (PCO) -- Prepaid Health Plan that contracts with OMAP to provide partially capitated health services under

the Oregon Health Plan. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(95) Post Hospital Extended Care Benefit -- A 20 day benefit for non-Medicare OMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(96) Post Stabilization Services -- covered services, related to an Emergency Medical Condition that are provided after an OMAP Member is stabilized in order to maintain the stabilized condition or to improve or resolve the OMAP Member's condition.

(97) Potential OMAP Member — An OHP client who is subject to mandatory enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

(98) Practitioner -- A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(99) Prepaid Health Plan (PHP) -- A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with OMAP and/or OMHAS on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), Physician Care Organizations (PCOs) or Chemical Dependency Organizations (CDOs).

(100) Preventive Services -- Those services as defined under Expanded Definition of Preventive Services for Oregon Health Plan clients in OAR 410-141-0480, The Oregon Health Plan Benefit Package of covered services, and OAR 410-141-0520, Prioritized List of Health Services.

(101) Primary Care Management Services -- Primary Care Management Services are services provided to ensure PCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are

preventive or primary care services or PCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(102) Primary Care Manager (PCM) -- A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Management Services as defined in rule to PCM Members. Primary Care Managers may also be hospital primary care clinics, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCM provides Primary Care Management Services to PCM Members for a Capitation Payment. The PCM provides preventive and primary care services on a fee-for-service basis.

(103) Primary Care Dentist (PCD) – A Dental Practitioner who is responsible for supervising, coordinating initial and primary dental care within their scope of practice for OMAP Members. Primary Care Dentists initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(104) Primary Care Provider (PCP) -- A practitioner who has responsibility for supervising, coordinating initial and primary care within their scope of practice for OMAP Members, Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically or dental appropriate care.

(105) Prioritized List of Health Services -- The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

(106) Proof of Indian Heritage -- Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service -- services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of

degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(107) Provider -- An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(108) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(109) Representative -- A person who can make Oregon Health Plan related decisions for Oregon Health Plan Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the Oregon Health Plan Client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the Oregon Health Plan client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(110) Rural -- A geographic area 10 or more map miles from a population center of 30,000 people or less.

(111) Seniors and People with Disabilities (SPD) -- The Cluster within DHS responsible for providing services such as:

(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;

(b) Cash assistance grants for persons with long-term disabilities through General Assistance and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(112) Service Area -- The geographic area in which the PHP has identified in their Contract or Agreement with DHS to provide services under the Oregon Health Plan.

(113) Stabilize -- no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(114) Terminal Illness -- An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(115) Triage -- Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(116) Urban -- A geographic area less than 10 map miles from a population center of 30,000 people or more.

(117) Urgent Care Services -- Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of an OMAP Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services

(118) Valid Claim -- An invoice received by the PHP for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules; and

(c) A Valid Claim means a Claim received by a PHP for payment of Covered Services rendered to an OMAP client which (1) Can be processed without obtaining additional information from the Provider of the service or

from a third party; and (2) Has been received within the time limitations prescribed in OHP Rules. A Valid Claim does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A Valid Claim is synonymous with the federal definition of a Clean Claim as defined in 42 CFR 447.45(b).

(119) Valid Pre-Authorization -- A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-05

410-141-0010 Screening and Selection Procedures for Managed Care Services by Prepaid Health Plans

(1) Basis and scope:

(a) This rule establishes the screening and selection procedures that DHS will use to procure Managed Care Services pursuant to ORS 414.725 from a qualified Managed Care Organization that may be awarded a Contract as a prepaid managed health care services organization (Prepaid Health Plan or PHP) for purposes of administering the Oregon Health Plan;

(b) The Oregon Health Plan is funded with federal Medicaid funds. These rules will be interpreted and applied to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with PHPs. DHS will seek prior federal approval of PHP contracts;

(c) For purposes of source selection and screening in the procurement of Managed Care Services, DHS may use:

(i) The Request for Application (RFA) process described in subsections (3) to (6) of this rule; or

(ii) Any method for source selection and procurement process described in the DOJ Model Rules incorporated by Subsection (7) of this rule, except for bidding.

(2) Definitions for screening and selection rules:

(a) In addition to the terms defined in OAR 410-141-0000, the following terms have the following meanings:

(A) Addendum or Addenda means an addition or deletion to, a material change in, or general interest explanation of a RFA;

(B) Application means the documents submitted by a Managed Care Organization that seeks qualification to be Awarded a Contract. Applicant means the Managed Care Organization submitting the Application;

(C) Award means, as the context requires, the act or occurrence of DHS' identification of a qualified Managed Care Organization with which DHS will enter into a Contract;

(D) Closing means the date and time announced in a RFA as the deadline for submitting Applications;

(E) Managed Care Organization means a corporation, governmental agency, public corporation or other legal entity that operates as a managed health, dental, chemical dependency, physician care, or mental health organization;

(F) Managed Care Services means Capitated Services provided by a Prepaid Health Plan pursuant to ORS 414.725;

(G) Offer means a response to an RFA, including all required responses and assurances, and the Certification of Application;

(H) Request for Applications (RFA) means all documents used by DHS for soliciting Applications for qualification in a specific Request for Applications issued by DHS, for one or more categories of Contracts, one or more Service Areas or such other objective as DHS may determine is appropriate for solicitation of Managed Care Services.

(3) RFA Process:

(a) The RFA process begins with a public notice of the RFA, which will be communicated with the electronic notification system used by DHS to notify the public of procurement opportunities. A public notice of a RFA shall identify the qualification requirements for the category of contract (e.g., FCHP, DCO, etc.), the designated Service Area(s) where Managed Care Services are requested or other objective that DHS determines appropriate for solicitation of Managed Care Services, and a sample Contract;

(b) In order to enter into a Contract with DHS as a PHP, a Managed Care Organization must be determined by DHS to be qualified and comply with the terms and conditions in the Contract, consistent with subsection (4) of this rule:

(A) In order to receive a determination concerning whether a Managed Care Organization is qualified, an individual authorized to act for the Managed Care Organization (the Applicant) must complete all elements of the Application requirements contained in the RFA;

(B) If a Managed Care Organization currently has a PHP contract with DHS, it must still complete a new Application; however, to avoid duplication and burden, a current contractor may generally be permitted to submit an abbreviated Application that focuses only on additional or different requirements specific to the new Contract or the new Service Area or capacity or other DHS objective that is the subject of the RFA;

(c) DHS enters into or renews a Contract only if it determines that action would be within the scope of the RFA and consistent with the effective administration of the medical assistance program, including but not limited to:

(A) The capacity of any existing PHP(s) in the Service Area compared to the capacity of an additional PHP for the number of potential enrollees in the Service Area;

(B) The number of potential enrollees in the Service Area compared to the capacity of any existing PHP(s) by a wide enough margin to form an enrollment base for an additional PHP in the Service Area; and

(C) The potential opportunity for recipients to have a choice of more than one PHP;

(d) Notice of RFA:

(A) DHS will provide public notice of every RFA by posting notice of the RFA on the electronic system for notifying the public of DHS procurement opportunities, or at the option of the requestor, mailing notice of the availability of the RFA to persons that have expressed interest in DHS procurement of Managed Care Services;

(B) DHS will provide notice of any Addenda to an RFA in a manner intended to foster competition and to make prospective Applicants aware of

the Addenda. The RFA will specify how DHS will provide notice of Addenda;

(e) If the RFA so specifies, potential Applicants must submit a letter of intent to DHS within the time period specified in the RFA. While a letter of intent does not commit any potential Applicant to apply, DHS will not consider Applications from Applicants who do not submit a timely letter of intent;

(f) Application. The Application must be submitted in conformity with the requirements of the RFA. All questions must be answered and all information, including attachments, must be submitted in one complete packet by the Application due date:

(A) The RFA will describe the manner in which Applications may be submitted, electronically or otherwise. DHS is not responsible for any failure attributable to the transmission or receipt of electronic or facsimile Applications, including but not limited to receipt of garbled or incomplete documents, delay in transmission or receipt of documents, or security and confidentiality of data. DHS will not consider electronic or facsimile Applications unless authorized by the RFA and made in conformance with the RFA;

(B) To ensure proper identification and handling, Applications shall be submitted in a sealed envelope appropriately marked. If DHS permits electronic or facsimile Applications in the Solicitation Document, the Applicant may submit and identify electronic or facsimile Applications in accordance with the instructions set forth in the RFA;

(C) The Applicant is responsible for ensuring DHS receives its Application at the required delivery point prior to the Closing, regardless of the method used to submit or transmit the Application;

(D) The Closing date for the Application will be announced in the RFA. DHS will not accept late Applications;

(g) Disclosure of Application Contents and Release of Information:

(A) Application information, including the letter of intent, shall not be disclosed to any Applicant (or other person) until the completion of the RFA process. The RFA process shall be considered complete when a Contract has been Awarded. No information will be given to any Applicant (or other person) relative to their standing with other Applicants during the RFA process;

(B) Application information shall be subject to disclosure upon the Award date, with the exception of information that has been clearly identified and labeled “Confidential” under ORS 192.501 – 192.502, insofar as DHS determines it meets the requirements for an exemption from disclosure;

(C) Any requestor shall be able to obtain copies of non-exempt information after the RFA process has been completed. The requestor shall be responsible for the time and material expense associated with the request. This fee includes the copying of the document(s) and the staff time (and agency attorney time, if requested by DHS) associated with performing the task, in accordance with ORS 192.440(3). DHS may require prepayment of estimated charges before acting on a request;

(h) Any Applicant may submit a written protest or request for change of a particular RFA provision, specifications or contract terms and conditions to DHS no later than the solicitation protest date specified in the RFA. The protest shall state the reasons for the protest or request and any proposed changes to the RFA provisions, specifications or contract terms and conditions that the prospective Applicant believes will remedy the conditions upon which the protest is based. Protests and judicial review of the RFA shall be handled using the process set forth in OAR 137-047-0730;

(i) DHS is not obligated to enter into a Contract with any Applicant, and further, has no financial obligation to any Applicant.

(4) Application for qualification:

(a) A Managed Care Organization seeking qualification as a PHP must meet the requirements and provide the assurances specified in the RFA. DHS determines whether the Managed Care Organization qualifies based

on the Application and any additional information and investigation that DHS may require;

(b) DHS determines that a Managed Care Organization is qualified if DHS finds that the Managed Care Organization meets the requirements of the RFA, including written assurances, satisfactory to DHS, that it:

(A) Provides or will provide the services described in the Contract;

(B) Provides or will provide these services in the matter described in the Contract;

(C) Is organized and operated, and will continue to be organized and operated, in the manner required by the Contract and described in the Application;

(D) Under arrangements that safeguard the confidentiality of patient information and records, will provide to DHS, CMS, the Office of Inspector General, the Oregon Secretary of State, and the Oregon Medicaid Fraud Unit of the Department of Justice, or any of their duly authorized representatives, for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the Managed Care Organization relating to its operation as a PHP and to any facilities that it operates; and

(E) Will continue to comply with any other assurances it has given DHS.

(c) DHS may determine that a Managed Care Organization is potentially qualified if within a specified period of time the Managed Care Organization is reasonably susceptible of being made qualified. DHS is not obligated to determine whether an Applicant is potentially qualified if, in its discretion, DHS determines that sufficient qualified Applicants are available to obtain DHS' objectives under the RFA. DHS determines that a Managed Care Organization is potentially qualified if:

(A) DHS finds that the Managed Care Organization is reasonably susceptible of meeting the operational and solvency requirements of the Application within a specified period of time; and

(B) The Managed Care Organization enters into discussions with DHS about areas of qualification that must be met before the Managed Care Organization is operationally and financially qualified, and a time period for providing documentation that is acceptable to DHS and provides written assurances, satisfactory to DHS, that it meets the requirements of a qualified Managed Care Organization in accordance with subsection (a) of this section;

(C) If DHS determines that a potentially qualified Applicant cannot become a qualified Managed Care Organization within the time announced in the RFA for Contract Award, DHS may:

(i) Offer the Contract at a future date when the Applicant demonstrates, to DHS' satisfaction, that Applicant is a qualified Managed Care Organization within the scope of the advertised RFA; or

(ii) Inform the Applicant that it is not qualified for Contract Award.

(5) Evaluation and determination procedures:

(a) DHS evaluates an Application for qualification on the basis of information contained in the RFA, the Application itself and any additional information that DHS obtains. Evaluation of the Application will be based on the criteria in the RFA;

(b) DHS will notify each Managed Care Organization that applies for qualification of its qualification status;

(c) Review of DHS' qualification decisions shall be as set forth in ORS 279B.425;

(d) DHS may enter into negotiation with qualified or potentially qualified Applicants concerning potential capacity and potential enrollment in relation to other available, or potentially available, capacity and the number of potential enrollees within the Service Area. DHS may determine that it will limit Contract Award(s) to fewer than the number of qualified or potentially qualified Applicants, to achieve the objectives in the RFA.

(6) Contract award conditions:

(a) The Applicant's submission of the Application with the executed Certification of Application is the Managed Care Organization's Offer to enter into a Contract. The Offer is a "Firm Offer," i.e., the Offer shall be held open by the Applicant for DHS' acceptance for the period specified in the RFA. DHS' Award of the Contract constitutes acceptance of the Offer and binds the Applicant to the Contract;

(b) No Contingent Offers. Except to the extent the Applicant is authorized to propose certain terms and conditions pursuant to the RFA, a Managed Care Organization shall not make its Offer contingent upon DHS's acceptance of any terms or conditions other than those contained in the Solicitation Document;

(c) By timely signing and submitting the Application and Certification of Application, the Applicant acknowledges that it has read and understands the terms and conditions contained in the RFA and that it accepts and agrees to be bound by the terms and conditions of the RFA;

(d) DHS may Award multiple Contracts in accordance with the criteria set forth in the RFA. DHS may make a single Award or limited number of Awards rather than multiple Awards to all qualified or potentially qualified Applicants, in order to meet DHS' needs including but not limited to adequate capacity for the potential enrollees in the Service Area;

(e) An Applicant who claims to have been adversely affected or aggrieved by DHS Contract Award or intent to Award a Contract must file a written protest with the DHS issuing office within seven (7) calendar days after receiving notice of Award. Protests and judicial review of Contract Award shall be handled using the procedures set forth in OAR 137-047-9740.

(7) Applicability of DOJ Model Rules: Except where inconsistent with the preceding subsections of this rule, DHS adopts the DOJ Model Rules to govern solicitations for Managed Care Services:

(a) OAR 137-046 – General Provisions Related to Public Contracting: OAR137-046-0100, OAR 137-046-0110 and OAR137-046-0400 through OAR 137-046-0480;

(b) OAR 137-047 – Public Procurements for Goods or Services: OAR 137-047-0100, OAR 137-047-0260 through OAR 137-047-0330, OAR 137-047-0400 through OAR 137-047-0800.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

10-1-05 (T)

410-141-0020 Administration of Oregon Health Plan Regulation and Rule Precedence

(1) The Department of Human Services (DHS) and its Office of Medical Assistance Programs (OMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), ORS 414.725 (Prepaid Health Plans), and ORS 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, OMAP will construe them as much as possible to be complementary. In the event that OMAP policies, procedures, rules and interpretations may not be complementary, OMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to OMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, OMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(i) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted OMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(ii) Oregon Revised Statutes governing medical assistance programs;

(iii) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to OMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, OMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(iv) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to

OMAP Clients are provided in OMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520,and the provider rules applicable to the category of medical service; and

(v) Any other applicable duly promulgated rules issued by OMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs.

(b) For purposes of contract administration solely as between OMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to OMAP Clients.

(i) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(ii) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

10-1-05

410-141-0060 Oregon Health Plan Managed Care Enrollment Requirements

(1) Enrollment of an Oregon Health Plan (OHP) Client, excluding the New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) clients in Prepaid Health Plans (PHPs) shall be mandatory unless exempted from Enrollment by the Department of Human Services (DHS), or unless the OHP Client resides in a Service Area where there is inadequate capacity to provide access to Capitated Services for all OHP Clients through PHPs or Primary Care Managers (PCMs). PHPs include Fully Capitated Health Plans (FCHPs), Dental Care Organizations (DCOs) and Mental Health Organizations (MHOs), Physician Care Organizations (PCOs), and Chemical Dependency Organizations (CDOs).

(2) Enrollment of the New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) Client in PHPs shall be mandatory unless exempted from Enrollment by DHS under the term in 410-141-0060(4). Selection of PHPs in accordance with this rule is a condition of eligibility for HPN and CHIP Clients. If, upon reapplication, an HPN and CHIP Clients do not select PHPs in accordance with this rule, PHPs will be selected for the HPN and CHIP Client by DHS. This selection will be made based on the PHPs in which the HPN and CHIP Clients were previously enrolled.

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

(a) Areas with sufficient physical health service capacity through a combination of FCHPs, PCOs, and PCMs shall be called mandatory FCHP/PCO/PCM Service Areas. An OHP Client shall select a FCHP or PCO unless exempted from Enrollment in a FCHP and PCO, in which case they shall choose a PCM in a mandatory FCHP/PCO/PCM Service Area;

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

(c) Service Areas without sufficient physical health service capacity through FCHPs, PCOs and PCMs shall be called voluntary

FCHP/PCO/PCM Service Areas. An OHP Client may choose to select a FCHP, PCO or PCM in voluntary FCHP/PCO/PCM Service Areas if the FCHP. PCO or PCM is open for Enrollment, or may choose to remain in the Medicaid Fee-for-Service (FFS) physical health care delivery system;

(d) Service Areas with sufficient dental care service capacity through DCOs shall be called mandatory DCO Service Areas. An OHP Client shall select a DCO in a mandatory DCO Service Area;

(e) Service Areas without sufficient dental care service capacity through DCOs shall be called voluntary DCO Service Areas. An OHP Client may choose to select a DCO in a voluntary DCO Service Area if the DCO is open for Enrollment, or may choose to remain in the Medicaid FFS dental care delivery system;

(f) Service Areas with sufficient mental health service capacity through MHOs shall be called mandatory MHO Service Areas. An OHP Client shall select an MHO in a mandatory MHO Service Area;

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

(h) When a Service Area changes from mandatory to voluntary, the OMAP Member will remain with their PHP for the remainder of their eligibility period, unless the OMAP Member meets the criteria stated in OAR 410- 141-0060(4), or as provided by OAR 410-141-0080.

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

(a) The OHP Client is covered under a major medical insurance policy, such as a Medicare supplemental policy, Medicare employer group policy or other third party resource (TPR) which covers the cost of services to be provided by a PHP, (excluding dental insurance. An OHP Client shall be enrolled with a DCO even if they have a dental

TPR). The OHP Client shall enroll with a PCM if the insurance policy is not a private HMO;

(b) The OHP Client has an established relationship with an OMAP enrolled Practitioner who is not a member of the PHP's Participating Provider panel the OHP Client would be enrolled in, and the PHP cannot negotiate a treatment plan or reimbursement arrangement with the Practitioner that is consistent with the PHP's contracting practices to provide for continuity of care, and it would be detrimental to the health of the OHP Client as determined by DHS to change Practitioners:

(A) When the Practitioner is a Primary Care Practitioner (PCP) enrolled with OMAP as a PCM, the OHP Client shall enroll with this Practitioner as a PCM Member;

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

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

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

(d) The OHP Client is a child in the legal custody of either the Oregon Youth Authority (OYA) or Children, Adults and Families Services (CAFS) (SOSCF services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless one of the following conditions exist:

(A) There is no fee-for-service access; or

(B) There is continuity of care issues.

(e) The OHP Client is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination, and she wishes to continue obtaining maternity services from a Practitioner who is not a Participating Provider with an FCHP or PCO in the Service Area:

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

(B) If the OMAP Member moves out of the PHP's Service Area during the third trimester, the OMAP Member may be exempted from Enrollment in the new Service Area for continuity of care if the OMAP Member wants to continue Obstetric care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-0220(1)(a) Oregon Health Plan PHP Accessibility;

(C) If the Practitioner is a PCM; the OMAP Member shall enroll with that Practitioner as a PCM Member;

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

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

(g) The OHP Client has been accepted by the Medically Fragile Children's Unit of the Office of Mental Health and Addiction Services (OMHAS);

(h) The OHP Client is a Medicare beneficiary and is in a hospice program shall not enroll in an FCHP or PCO that is also a Medicare Cost HMO. The OHP Client may enroll in either an FCHP or PCO that does not have a Medicare Cost HMO or with a PCM unless exempt for some other reason listed in section (4) of this rule;

(i) The OHP Client is enrolled in Medicare and the only FCHP or PCO in the Service Area is a Medicare HMO. The OHP Client may be exempted from Enrollment in the FCHP or PCO if the OHP Client chooses not to enroll;

(j) If an OMAP Member is enrolled in a program participating in the Intensive Treatment Service Pilot Project, the OMAP Member shall remain enrolled in the MHO he/she was enrolled in prior to the placement;

(k) Other just causes as determined by DHS, at its sole discretion, which include the following factors:

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

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

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

(D) The lack of reasonable alternatives.

(l) A woman eligible for the Breast and Cervical Cancer Medical (BCCM) Program, (refer to BCCM rules established by Children, Adult and Families Services), shall not enroll in an FCHP, PCO, DCO or MHO. A woman in the BCCM Program shall remain in the Medicaid fee-for-service delivery system.

(5) The primary person in the household group and benefit group as defined in OAR 461-110-0110, OAR 461-110-0210, and OAR 461-110- 0720, respectively, shall select PHPs or PCMs on behalf of all OHP Clients in the benefit group. PHP or PCM selection shall occur at the time of application for the OHP in accordance with section (1) of this rule: (a) All OHP Clients in the benefit group shall enroll in the same PHP for each benefit type (physical, dental or mental health care) unless exempted under the conditions stated above in section (4). If PCM selection is an option, OHP Clients in the benefit group may select different PCMs;

(b) If the OHP Client is not able to choose PHPs or PCMs on his or her own, the Representative of the OHP Client shall make the

selection. The hierarchy used for making Enrollment decisions shall be in descending order as defined under Representative:

(A) If the OHP form 7208M, Medicare+Choice election form is signed by someone other than the OHP Client, the OHP Client's Representative must complete and sign an Addendum. The Addendum is incorporated as part of the 7208M and is located on page four (4) of the form:

(i) If the FCHP or PCO does not receive the 7208M within 10 calendar days after the date of Enrollment, the FCHP or PCO shall send a letter to the OMAP Member with a copy sent to the Seniors and People with Disabilities (SPD) branch manager. The letter shall:

(I) Explain the need for the completion of the 7208M;

(II) Notify the OMAP Member, if the 7208M is not received within 30 days, the FCHP or PCO shall request Disenrollment; and

(III) Instruct the OMAP Member to contact their caseworker for other coverage alternatives.

(ii) If the FCHP or PCO has not received the 7208M at the end of 30 days, the FCHP or PCO shall notify OMAP's Health Management Unit (HMU). HMU shall disenroll the OMAP Member effective the end of the month following the notification and notify the OMAP Member of the Disenrollment. HMU shall provide SPD with the OHP Client Disenrollment list.

(B) If the OHP Client is a Medicare beneficiary who is capable of making Enrollment decisions, the Representative shall not have authority to select FCHPs or PCOs that have corresponding Medicare HMO components.

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

(d) Enrollment in a FCHP or PCO of an OHP Client who is receiving Medicare and who resides in a Service Area served by PHPs or PCMs shall be as follows:

(A) If the OHP Client selects a FCHP or PCO that has a corresponding Medicare HMO, the OHP Client shall also enroll in the Medicare HMO;

(B) If the OHP Client is enrolled as a private member of a Medicare HMO, the OHP Client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare HMO:

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

(ii) If the OHP Client chooses to discontinue the Medicare HMO enrollment and then, within 60 calendar days of disenrollment from the Medicare HMO, chooses the FCHP or PCO that corresponds to the Medicare HMO that was discontinued, the OHP Client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other OHP Clients;

(iii) A Dual Eligible (DE) OHP Client who has been exempted from Enrollment in an MHO shall not be enrolled in a FCHP or PCO that has a corresponding Medicare HMO unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

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

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

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

(6) If the OHP Client resides in a mandatory Service Area and fails to select a DCO, MHO, PCO and/or FCHP or a PCM at the time of application for the OHP, OMAP may enroll the OHP Client with a DCO, MHO, PCO and/or FCHP or a PCM:

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

(A) Is open for Enrollment;

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

(C) Has Practitioners located within the Community Standard distance for average travel time for the OHP Client.

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

(c) DHS shall send a notice to the OHP Client informing the OHP Client of the assignments and the right to change assignments within 30 calendar days of Enrollment. A change in assignment shall be honored if there is another DCO, MHO, and FCHP, PCO or PCM open for Enrollment in the county in which the OHP Client resides;

(d) Enrollments resulting from assignments shall be effective the first of the month or week after DHS enrolls the OHP Client and notifies the OHP Client of Enrollment and the name of the PHP or PCM: If Enrollment is initiated by a DHS worker on or before Wednesday, the date of Enrollment shall be the following Monday. If Enrollment is initiated by a DHS worker after Wednesday, the date of Enrollment shall be one week from the following Monday. Monthly Enrollment in a mandatory Service Area where there is only one FCHP, PCO, MHO or DCO shall be initiated by an auto- Enrollment program of DHS with effective dates the first of the month following the month-end cutoff. Monthly Enrollment in Service Areas where there is a choice of PHPs, shall be auto-Enrolled by computer algorithm.

(7) The provision of Capitated Services to an OMAP Member enrolled with a PHP or a PCM shall begin on the first day of Enrollment with the PHP or a PCM except for:

(a) A newborn whose mother was enrolled at the time of birth. The date of Enrollment shall be the newborn's date of birth;

(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of Enrollment with a FCHP, PCO or MHO shall be

the first possible Enrollment date after the date the OHP Client is discharged from inpatient hospital services and the date of Enrollment with a PCM shall be the first of the month for which Capitation Payment is made;

(c) For OMAP Members who are re-enrolled within 30 calendar days of Disenrollment. The date of Enrollment shall be the date specified by DHS that may be retroactive to the date of Disenrollment;

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

(e) For children or adolescents enrolled into an MHO on the day of admission to Psychiatric Residential Treatment Services (PRTS), the MHO shall be responsible for said services. If the OMAP Member is enrolled after the first day of admission to the PRTS, the OMAP Member shall be Disenrolled and the date of the enrollment shall be the first day of the month following discharge from the PRTS.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

10-1-05

410-141-0070 Oregon Health Plan Fully Capitated Health Plan (FCHP) and Physician Care Organization (PCO) Pharmaceutical Drug List Requirements

(1) Prescription drugs are a covered service based on the funded condition treatment pairs. The FCHPs and PCOs shall pay for prescription drugs except:

(a) As otherwise provided, such as Class 7 & 11 medications (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Those specifically carved out by OMAP; and

(c) Any applicable co-payments.

(2) FCHPs and PCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization. The drug list must:

(a) Include FDA-approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) FCHPs and PCOs shall provide their Participating Providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates the FCHP or PCO makes to their drug list within 30 days of a change which may include, but is not limited to:

Addition of a new drug;

Removal of a previously listed drug; and

Generic substitution.

(4) If a drug cannot be approved within the 24-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, FCHPs and PCOs must provide for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.

(5) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The drug listed equivalent has been ineffective in the treatment or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the OMAP Member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less-Than-Effective drugs which have reached the Federal Drug Administration Notice-of-Opportunity-for Hearing stage. The DESI Less-Than-Effective list is available at OMAP's website address: http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/misc_files/desi1.pdf

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
5-1-05

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

(1) Office of Medical Assistance Programs (OMAP) Member Requests for Disenrollment:

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

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

(A) Without cause:

(i) After six months of OMAP Member's Enrollment. The effective date of Disenrollment shall be the first of the month following the Department's approval of Disenrollment;

(ii)Whenever an OMAP Member's eligibility is redetermined by the Department of Human Services (DHS) and the primary person requests Disenrollment without cause. The effective date of Disenrollment shall be the first of the month following the date that the OMAP Member's eligibility is redetermined by the Department;

(B) With cause:

(i) At any time;

(ii) OMAP Members who disenroll from a Medicare Health Maintenance Organization (HMO) shall also be Disenrolled from the corresponding Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). The effective date of Disenrollment shall be the first of the month that the OMAP Member's Medicare HMO Disenrollment is effective;

(iii) OMAP Members who are receiving Medicare and who are enrolled in a FCHP or PCO that has a corresponding Medicare

HMO/Medicare+Choice (M+C) component may disenroll from the FCHP or PCO at any time if they also request Disenrollment from the Medicare HMO. The effective date of Disenrollment from the FCHP or PCO shall be the first of the month following the date of request for Disenrollment;

(iv) PHP does not, because of moral or religious objections, cover the service the OMAP Member seeks;

(v) The OMAP 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 OMAP Members' Primary Care Provider or another Provider determines that receiving the services separately would subject the OMAP Member to unnecessary risk; or

(vi) 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 OMAP Member's health care needs. 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 (FFS) delivery system;

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

(C) If the following conditions are met:

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

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

(iii) The request to change FCHPs, PCOs or return to FFS 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 PHP 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;

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

(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 the Centers for Medicare and Medicaid Services (CMS), if a Medicare member Disenrolled in a FCHP’s or PCO's Medicare HMO/M+C. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of missed appointments is to be established by the Provider or PHP. The number must be the

same as for commercial members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the OMAP Member in receiving services. This rule does not apply to Medicare members who are enrolled in a FCHP’s or PCO's Medicare HMO/M+C;

(ii) OMAP 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 OMAP Member or other members, except as excluded in (b)(B)(vii);

(iii) OMAP 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) OMAP 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 or PHP’s premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) Fraud Unit as appropriate;

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

(vi) OMAP Member fails to pay co-payment(s) for Covered Services as described in OAR 410-120-1230 and/or 410-120-1235.

(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 OMAP Member's health;

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

(iv) Because the OMAP Member requests a hearing;

(v) Because the OMAP Member has been diagnosed with End Stage Renal Disease (ESRD);

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

(vii) Because of uncooperative or disruptive behavior resulting from the OMAP Member's special needs (except when continued Enrollment seriously impairs the PHP's ability to furnish services to either this OMAP Member or other members.

(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 OMAP 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 the OMAP 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 OMAP 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 OMAP Member's record. The PHP shall inform the OMAP Member that his/her continued behavior may result in Disenrollment from the PHP;

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

(iv) The PHP shall contact the OMAP 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, OMAP Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain an authorization for release of information from the OMAP Member for the Providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the OMAP Member's record;

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

(D) If the problem persists, the PHP may request Disenrollment of the OMAP Member by submitting a written request to Disenroll the OMAP Member to the PHP’s OMAP PHP Coordinator, with a copy to the OMAP 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 the OMAP 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 Mental Health and Addiction Services;

(vi) If the OMAP 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 specialist to assess the behavior, the behavioral 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 OMAP 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 OMAP Member a letter within 14 days after the request was approved, with a copy to the OMAP Member's DHS caseworker and OMAP's Health Management Unit (HMU), except in cases where the OMAP Member is also enrolled in a FCHP's or PCO's Medicare HMO/M+C. The letter must give the Disenrollment date, the reason for Disenrollment, and the notice of OMAP Member's right to file a Complaint (as specified in 410-141-0260 through 410-141-0266) and to request an Administrative Hearing;

(v) In cases where the OMAP Member is also enrolled in a FCHP's or PCO's Medicare HMO/M+C, 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 OMAP Member shall not be disenrolled from the PHP's OHP Plan;

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

(vii) The PHP Coordinator will determine when Enrollment in another PHP or with a PCM is appropriate. The PHP Coordinator will contact the OMAP Member's DHS caseworker to arrange Enrollment;

(viii) When the Disenrollment date has been determined, HMU sends a letter to the OMAP Member with a copy to the OMAP Member's

DHS caseworker and the PHP. The letter shall inform the OMAP Member of the requirement to be enrolled in another PHP.

(F) If the PHP Coordinator approves 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 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) 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 FFS Providers or a PCM until such time as they can be enrolled in another PHP;

(v) At the time of Enrollment into another PHP, OMAP shall notify the new PHP that the OMAP Member and/or benefit group were previously Disenrolled from another PHP at that PHP’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 into another PHP, OMAP shall notify the new PHP that the OMAP Member and/or benefit group were previously Disenrolled from another PHP at that PHP’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 PHP's PHP Coordinator. An OMAP Member may not be Disenrolled from the same PHP for a period of more than 12 months. If the OMAP Member is reenrolled 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 OMAP Member is admitted to the hospital, the FCHP or MHO shall be responsible for said hospitalization. If the OMAP Member is enrolled after the first day of the inpatient stay, the OMAP Member shall be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from inpatient hospital services;

(B) The OMAP 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 OMAP Member wishes to have the services performed by that Provider;

(C) The Medicare member is enrolled in a Medicare Cost Plan and was receiving Hospice Services at the time of Enrollment in the PHP;

(D) The OMAP 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 OMAP Member from the PHP, if the OMAP Member no longer resides in the PHP's Service Area. OMAP 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 from the PHP;

(G) The OMAP 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 OMAP 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 OMAP Members and providing sufficient proof of incarceration to HMU for review of the Disenrollment request. OMAP will approve requests for Disenrollment from PHPs for OMAP Members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHPs are responsible for inpatient services only during the time an OMAP Member was an inmate;

(H) For children or adolescents enrolled into an MHO on the day of admission to Psychiatric Residential Treatment Services (PRTS), the MHO shall be responsible for said services. If the OMAP Member is enrolled after the first day of admission to the PRTS, OMAP Member shall be Disenrolled and the date of the enrollment shall be the first day of the month following discharge from the PRTS; or

(I) The OMAP 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 FFS 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 from the PHP;

(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/M+C, 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;

(F) If OMAP determines that Contractor’s OMAP Member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP the effective date of the Disenrollment shall be the OMAP Member’s effective date of coverage with FHIAP.

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

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

Stat. Auth.: ORS Chapter 409
Stats. Implemented: 414.065

10-1-05

410-141-0085 Oregon Health Plan Disenrollment from Primary Care Managers

(1) PCM Member requests for Disenrollment:

(a) All PCM Member-initiated requests for Disenrollment from Primary-Care Managers must be initiated by the primary person in the benefit group, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For PCM Members who are not able to request Disenrollment on their own, the request may be initiated by the PCM Member's Representative;

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

(A) During the first 30 days of Enrollment without cause. The effective date of Disenrollment shall be the first of the month following PCM Member notification to DHS;

(B) After six months of PCM Member's Enrollment without cause. The effective date of Disenrollment shall be the first of the month following PCM Member notification to DHS;

(C) Whenever a PCM Member's eligibility is re-determined by and the primary person requests Disenrollment without cause. The effective date of Disenrollment shall be the first of the month following the date that PCM Member's eligibility is re-determined by DHS;

(D) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for Disenrollment;

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

(I) The PCM Member moves out of the Primary Care Manager Service Area;

(II) It would be detrimental to the PCM Member's health to remain enrolled with the the Primary Care Manager;

(III) The PCM 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.

(c) In addition to the Disenrollment constraints listed in subsection (b) of this section, PCM Member Disenrollment requests are subject to the following requirements:

(A) The PCM Member shall select another Primary Care Manager or Prepaid Health Plan, unless the PCM Member resides in a Service Area where Enrollment is voluntary;

(B) If the only Primary Care Manager or Prepaid Health Plan available in a PHP, PHP/ PCM or PCM mandatory Service Area is the PCM from which the PCM Member wishes to disenroll, the PCM Member may not disenroll without cause.

(2) Primary Care Manager requests for Disenrollment:

(a) Procedures for Primary Care Manager requests for Disenrollment are as follows:

(A) Requests by the Primary Care Manager for Disenrollment of specific PCM Members shall be submitted in writing to OMAP for approval prior to Disenrollment. The Primary Care Manager shall document the reason for the request, provide other records to support the request, and certify that the request is not due to an adverse change in the PCM Member's health. If the situation warrants, OMAP shall consider an oral request for Disenrollment, with written documentation to follow. OMAP shall approve Primary Care Manager requests for Disenrollment that meet OMAP criteria;

(B) OMAP shall respond to Primary Care Manager requests in a timely manner and in no event greater than 30 calendar days;

(C) The Primary Care Manager shall not disenroll or request Disenrollment of any PCM Member because of an adverse change in the PCM Member's health.

(b) OMAP may disenroll PCM Members for cause when requested by the Primary Care Manager:

(A) OMAP shall inform the PCM Member of:

(i) An approved Disenrollment decision;

(ii) Any requirement to select another Primary Care Manager;

(iii) Right to request an OMAP hearing if the Disenrollment decision by OMAP is disputed.

(B) Examples of cause include, but are no limited to the following:

(i) The PCM Member refuses to accept Medically Appropriate treatment and/or follow Medically Appropriate guidelines;

(ii) The PCM Member is unruly or abusive to others or threatens or commits an act of physical violence directed at a medical Provider, the Provider's staff or other patients;

(iii) The PCM Member has permitted the use of his or her OMAP Medical Care Identification by another person or used another person's Medical Care Identification;

(iv) The PCM Member has missed three appointments without cancelling and/or without explanation and the Primary Care Manager has documented attempts to accommodate the PCM Member's needs and to counsel with or educate the PCM Member.

(c) If OMAP approves the Primary Care Manager request for Disenrollment of a PCM Member because the PCM Member is abusive to others or threatens or commits an act of physical violence, the following procedures shall apply:

(A) OMAP shall inform the PCM Member of the Disenrollment decision;

(B) The PCM Member shall be disenrolled. All PCM Members in the PCM Member's benefit group, as defined in OAR 461-110-0720, may be disenrolled;

(C) The effective date of Disenrollment shall be the date of the Primary Care Manager's request for Disenrollment;

(D) OMAP shall require the PCM Member and/or the benefit group to obtain services from fee-for-service Providers for six months;

(E) After six months the PCM Member and/or the benefit group shall be required to select another Primary Care Manager, if available in the Service Area;

(F) OMAP shall notify the new Primary Care Manager that the PCM Member and/or benefit group was previously disenrolled from another Primary Care Manager at the Primary Care Manager's request.

(3) OMAP may initiate and disenroll PCM Members as follows:

(a) If OMAP determines the PCM Member has third party resources through a private HMO, OMAP may disenroll the PCM Member. The effective date of Disenrollment shall be specified by OMAP and shall be the first of the month after OMAP determines the PCM Member should be disenrolled;

(b) If the PCM Member moves out of the Primary Care Manager’s Service Area, the effective date of Disenrollment shall be the date specified by OMAP, which may be retroactive up to one month prior to the month OMAP notifies the Primary Care Manager;

(c) If the PCM Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project, the effective date of Disenrollment shall be the date specified by OMAP;

(d) If the PCM Member dies, the effective date of Disenrollment shall be the date of death.

(4) Unless specified otherwise in this rule or at the time of notification of Disenrollment to the Primary Care Manager by OMAP all Disenrollments are effective the first of the month after the request for Disenrollment is approved by OMAP.

(5) Oregon Health Plan clients may request an OMAP hearing if they dispute a Disenrollment decision by OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725

410-141-0110 Oregon Health Plan Prepaid Health Plan Member Satisfaction Survey

(1) OMAP shall conduct a statistically valid FCHP OMAP Member satisfaction survey each calendar year to survey OMAP Members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General OMAP Member satisfaction.

(2) OMAP may conduct a statistically valid DCO and CDO OMAP Member satisfaction survey to survey OMAP Member satisfaction.

(3) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
5-1-05

410-141-0115 Oregon Health Plan Primary Care Manager Member Satisfaction Survey

(1) OMAP may conduct a statistically valid PCM member satisfaction survey each calendar year to survey PCM members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General PCM member satisfaction.

(2) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725

410-141-0120 Oregon Health Plan Prepaid Health Plan Provision of Health Care Services

CAF: Children, Adults and Families

CMS: Centers for Medicare and Medicaid Services

DHS: Department of Human Services

FCHP: Fully Capitated Health Plans

MHO: Mental Health Organization

OHP: Oregon Health Plan

OMAP: Office of Medical Assistance Programs

OMHAS: Office of Mental Health and Addiction Services

PCO: Physician Care Organization

PCP: Primary Care Provider

PHP: Prepaid Health Plan

(1) PHPs shall have written policies and procedures that ensure the provision of all Medically and Dentally Appropriate covered services, including Urgent Care Services and Emergency Services, Preventive Services and Ancillary Services, in those categories of services included in Contract or agreements with OMAP and/or OMHAS, respectively. PHPs shall communicate these policies and procedures to Providers, regularly monitor Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all Participating Providers providing covered services to OMAP Members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination, based on the requirements of the discipline or profession, that Participating

Providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on November 14, 2000, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities, including oversight of processes:

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

(B) PHPs shall provide training for PHP staff and Participating Providers and their staff regarding the delivery of covered services, OHP Administrative Rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank;

(D) PHPs shall not refer OMAP Members to or use Providers who have been terminated from the Oregon Medical Assistance Program or excluded as Medicare/Medicaid Providers by CMS and/or by any lawful conviction by a Court for which the Provider could be excluded under 42 CFR 1001.101. PHPs shall not accept billings for services to OMAP Members provided after the date of such Provider's conviction or termination.

(b) FCHPs, PCOs, DCOs and CDOs shall have written procedures that provide newly enrolled OMAP Members with information about which Participating Providers are currently not accepting new patients (except for staff models);

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

(d) If the OMAP Member does not choose a PCP within 30 calendar days from the date of Enrollment, the FCHP or PCO must ensure the OMAP Member has an ongoing source of primary care appropriate to his or her needs by formally designating a Practitioner or entity. FCHPs and PCOs that assign OMAP Members to PCPs or clinics shall document the unsuccessful efforts to elicit the OMAP Member's choice before assigning an OMAP Member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after Enrollment, must notify the OMAP Member of the assignment and allow the OMAP Member 30 calendar days after assignment to change the assigned PCP or clinic.

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

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

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) OMAP Members may receive the following services from appropriate Non-Participating Medicaid Providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the Oregon Health Plan), OMAP is responsible for payment of such services:

(A) Family planning services; and

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

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

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

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

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

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health Providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and/or planning committees;

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

(3) FCHPs and PCOs shall ensure a newly enrolled OMAP Member receives timely, adequate and appropriate health care services necessary to establish and maintain the health of the OMAP Member. An FCHP's liability covers the period between the OMAP Member's Enrollment and Disenrollment with the FCHP, unless the OMAP Member is hospitalized at the time of Disenrollment. In such an event,

an FCHP is responsible for the inpatient hospital services until discharge or until the OMAP Member's PCP or designated Practitioner determines the care is no longer Medically Appropriate.

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

(5) The OMAP Member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of Enrollment through the date of Disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for Capitated Services, and shall coordinate benefits for shared OMAP Members to ensure that the OMAP Member receives all Medically Appropriate services covered under respective Capitation Payments. If the Dual Eligible OMAP Member is enrolled in a FCHP or PCO with a Medicare HMO component the following apply:

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

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

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

(a) PHPs shall establish and maintain working relationships with Local or Allied Agencies, Community Emergency Service Agencies, and local Providers;

(b) PHPs shall refer OMAP Members to the Offices of the Department of Human Services and Local and Regional Allied Agencies which may offer services not covered under the Capitation Payment;

(c) FCHPs and PCOs shall not require OMAP Members to obtain the approval of a PCP in order to gain access to mental health and alcohol and drug assessment and evaluation services. OMAP Members may refer themselves to MHO services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 & ORS 442.807
5-1-05

410-141-0140 Oregon Health Plan (OHP) Prepaid Health Plan (PHP) Emergency and Urgent Care Services

(1) PHPs shall have written policies and procedures and monitoring systems that ensure the provision of appropriate Urgent, Emergency, and Triage services 24-hours a day, 7-days-a-week for all OMAP Members. PHPs shall:

(a) Communicate these policies and procedures to Participating Providers;

(b) Regularly monitor Participating Providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure Participating Provider's compliance. PHPs shall document all monitoring and corrective action activities.

(2) PHPs shall have written policies and procedures and monitoring processes to ensure that a Practitioner provides a Medically or Dentally Appropriate response as indicated to urgent or emergency calls consisting of the following elements:

(a) Telephone or face-to-face evaluation of the OMAP Member to determine the nature of the situation and the OMAP Member's immediate need for services;

(b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilizing the urgent or emergency situation;

(c) Development of a course of action at the conclusion of the assessment;

(d) Provision of services and/or referral needed to address the urgent or emergency situation, begin Post-Stabilization Care or provide outreach services in the case of an MHO;

(e) Provision for notifying a referral emergency room, when applicable concerning the presenting problem of an arriving OMAP Member, and

whether or not the Practitioner will meet the OMAP Member at the emergency room; and

(f) Provision for notifying other Providers requesting approval to treat OMAP Members of the determination.

(3) PHPs shall ensure the availability of an after-hours call-in system adequate to Triage urgent care and emergency calls from OMAP Members. Urgent calls shall be returned appropriate to the OMAP Member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.

(4) If a screening examination in an Emergency Room leads to a clinical determination by the examining physician that an actual emergency medical condition exists under the prudent layperson standard as defined in Emergency Services, the PHP must pay for all services required to stabilize the patient, except as otherwise provided in (6) of this rule. The PHP may not require prior authorization for Emergency Services:

(a) The PHP may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature;

(b) The PHP may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The PHP may not deny a claim for emergency services merely because the Primary Care Physician (PCP) was not notified, or because the PHP was not billed within 10 calendar days of the service.

(5) When an OMAP Member's Primary Care Provider, designated Practitioner or other health plan representative instructs the OMAP Member to seek emergency care, in or out of the network, the PHP is responsible for payment of the screening examination and for other Medically Appropriate services. Except as otherwise provided in (6) of

this rule, the PHP is responsible for payment of Post-Stabilization Care that was:

(a) Pre-authorized by the PHP;

(b) Not pre-authorized by the PHP if the PHP (or the on-call Provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PHP or Provider on call could not be contacted; or

(c) If the PHP and the treating physician cannot reach an agreement concerning the OMAP Member's care and a PHP representative is not available for consultation, the PHP must give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with care of the patient until a PHP physician is reached or one of the following criteria is met:

(A) The Participating Provider with privileges at the treating hospital assumes responsibilities for the OMAP Member's care;

(B) The Participating Provider assumes responsibility for the OMAP Member's care through transfer;

(C) A Contractor representative and the treating physician reach an agreement concerning the OMAP Member's care; or

(D) The OMAP Member is discharged.

(6) PCO responsibility with regard to Emergency Services, Urgent Care Services, or Post Stabilization Care Services is as follows:

(a) A PCO is not financially responsible for Emergency Services, Urgent Care Services, or Post Stabilization Services, to the extent such Services are Inpatient Hospital Services. The PCO shall not authorize, cause, induce or otherwise furnish any incentive for Emergency Services, Urgent Care Services, or Post Stabilization Services to be rendered as Inpatient Hospital Services except to the extent Medically Appropriate.

(b) A PCO is financially responsible for Post Stabilization Services (other than Inpatient Hospital Services) obtained by OMAP Members

within or outside the PCO's network under the following circumstances:

(A) Post Stabilization Services have been authorized by the PCO's authorized representative;

(B) Post Stabilization Services have not been authorized by the PCO's authorized representative, but are administered to maintain the OMAP Member's stabilized condition within 1 hour of a request to the PCO's authorized representative for approval of further Post Stabilization Services;

(C) Post Stabilization Services have not been authorized by the PCOs authorized representative, but are administered to maintain, improve, or resolve the OMAP Member's stabilized condition if:

(i) The PCO's authorized representative does not respond to a request for authorization within 1 hour;

(ii) The PCO's authorized representative cannot be contacted; or

(iii) The PCO's authorized representative and the treating physician cannot reach an agreement concerning the OMAP Member's care and the Participating Provider is not available for consultation. In this situation, the PCO must give the treating physician the opportunity to consult with the Participating Provider and the treating physician may continue with the care of the OMAP Member until the Participating Provider is reached or one of the criteria in Section (6) of this rule has been met.

(c) The PCO's financial responsibility for non-Inpatient Post Stabilization Services it has not approved ends when:

(A) The Participating Provider with privileges at the treating hospital assumes responsibilities for the OMAP Member's care;

(B) The Participating Provider assumes responsibility for the OMAP Member's care through transfer;

(C) A PCO representative and the treating physician reach an agreement concerning the OMAP Member's care; or

(D) The OMAP Member is discharged.

(7) PHPs shall have methods for tracking inappropriate use of emergency care and shall take Action, including individual OMAP Member counseling, to improve appropriate use of urgent and emergency care settings. DCOs and MHOs shall be responsible for taking action to improve appropriate use of urgent and emergency care settings for dental or mental health related care when inappropriate use of emergency care is made known to them through reporting or other mechanisms.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
5-1-05

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, delivery of primary care to and coordination of health care services for all OMAP 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 OMAP Member's Clinical Record;

(b) PHPs shall ensure OMAP Members receiving Exceptional Needs Care Coordination (ENCC) services for the Aged, Blind, Disabled, and special needs, as described in 410-141-0405, are noted in the appropriate OMAP 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 OMAP 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 OMAP 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 OMAP and/or OMHAS. 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 OMAP 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 OMAP Member shall obtain all covered services, either directly or upon referral, from the PHP or PCM responsible for the service from the date of Enrollment through the date of Disenrollment, except when the OMAP Member is enrolled in a Medicare HMO or Medicare+Choice (M+C) FCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or M+C and MHOs have significant and shared responsibility for prepaid services, and shall coordinate benefits for the OMAP Member to ensure that the OMAP Member receives all Medically Appropriate services covered under respective Capitation Payments;

(ii) If the OMAP Member is enrolled in a FCHP or PCO with a Medicare HMO component or M+C, 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 which ensure adequate prior notice of the referral to referral Providers and adequate documentation of the referral in the OMAP 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 that relevant medical, mental health, and/or 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 OMAP 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, and the staff in Alternative Care Settings, and 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 which ensure that an appropriate staff person responds to calls from other Providers requesting approval to provide care to OMAP 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 OMAP 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 an OMAP Member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:

(i) A notation is made in the OMAP 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 OMAP 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 OMAP 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 OMAP Members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure that the OMAP 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 OMAP Members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For OMAP 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 OMAP Members who are discharged to Post Hospital Extended Care, the FCHP shall notify the appropriate DHS 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 OMAP Member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the OMAP Member no later than two full working days prior to discharge from Post Hospital Extended Care. For OMAP 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 DHS office.

(5) PHPs shall coordinate the services the PHP furnishes to OMAP Members with the services the OMAP 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 OMAP 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 an OMAP Member's care is being transferred from one PHP to another or for OHP 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 OHP Client into the care of a PHP Participating Provider.

(7) PHPs shall make attempts to contact targeted OMAP population(s) by mail, telephone, in person or through the DHS agency 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 OMAP Member to his/her PCP or other resources as indicated by the assessment. Targeted OMAP population(s) shall be determined by the PHP and approved by OMAP.

(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 OMAP Member access to mental health services which are not provided under the Capitation Payment.

(9) MHOs shall ensure that OMAP 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 OMAP Members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for OMAP 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 OMAP Members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
5-1-05

410-141-0180 Oregon Health Plan Prepaid Health Plan Record Keeping

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

(2) Confidentiality and Privacy: PHPs and PHP's Participating Provides shall have written policies and procedures to ensure that Clinical Records related to OMAP Member's Individual Identifiable Health Information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through ORS 179.507, ORS 411.320, ORS 433.045 (3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50 If the PHP is a public body within the meaning of the Oregon public records law, such policies and procedures shall ensure that OMAP Member privacy is maintained in accordance with ORS 192.502(2), ORS 192.502(8) (Confidential under Oregon law) and ORS 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their Participating Providers shall not release or disclose any information concerning an OMAP Member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the OMAP Member;

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

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

(3) Access to Clinical Records:

(a) Provider Access to Clinical Records:

(A) PHPs shall release health service information requested by a Provider involved in the care of an OMAP Member within ten working days of receiving a signed authorization for release of information;

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

(b) OMAP Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' Participating Providers shall upon request, provide the OMAP Member access to his/her own Clinical Record, allow for the record to be amended or corrected and provide copies within ten working days of the request. PHPs' Participating Providers may charge the OMAP Member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' Participating Providers shall upon receipt of a written authorization for release of information for the OMAP Member provide access to OMAP Member's Clinical Record. PHPs' Participating Providers may charge for reasonable duplication costs;

(d) DHS Access to Records: PHPs shall cooperate with OMAP, the Office of Mental Health and Addiction Services (OMHAS), the Medicaid Fraud Unit, and/or OMHAS representatives for the purposes of audits, inspection and examination of OMAP Members' Clinical and Administrative Records.

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

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

(a) A Clinical Record shall be maintained for each OMAP Member receiving services that documents all types of care needed or delivered in all settings whether such services are delivered during or after normal clinic hours;

(b) All entries in the Clinical Record shall be signed and dated;

(c) Errors to the Clinical Record shall be corrected as follows. Incorrect data shall be crossed through with a single line. Correct and

legible data shall be added followed by the date corrected and initials of the person making the correction. Removal or obliteration of errors shall be prohibited;

d) The Clinical Record shall reflect a signed and dated authorization for treatment for the OMAP Member, his/her legal guardian or the Power of Attorney for Health Care Decisions for any invasive treatments;

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

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

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

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

(D) Dates of service;

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

(F) Physicians' orders;

(G) Pertinent findings on examination and diagnosis;

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

(I) Goods or supplies dispensed or prescribed;

(J) Description of treatment given and progress made;

(K) Recommendations for additional treatments or consultations;

(L) Evidence of referrals and results of referrals;

(M) Copies of the following documents if applicable:

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

(ii) Plans of care including evidence that the OMAP Member was jointly involved in the development of his/her mental health treatment plan;

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

(iv) Emergency department and screening services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided;

(N) Copies of signed authorizations for release of information forms;

(O) Copies of medical and/or mental health directives.

(f) Based on written policies and procedures, the Clinical Record keeping system developed and maintained by PHPs' Participating Providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the OMAP Member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;

(g) The PCP or clinic shall have policies and procedures that accommodate OMAP Member’s requesting to review and correct or amend their Clinical Record;

(h) Other Records: PHPs' shall maintain other records in either the Clinical Record or within the PHP's administrative offices. Such records shall include the following:

(A) Names and phone numbers of the OMAP Member's prepaid health plans, primary care physician or clinic, primary dentist and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) enrollment forms in the MHO's records;

(C) Copies of long term psychiatric care determination request forms in the MHO's records;

(D) Evidence that the OMAP Member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the OMAP Member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's or PCO's records;

(G) Complaint and Appeal records;

(H) Disenrollment Requests for Cause and the supporting documentation.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

10-1-05

410-141-0200 Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System

(1) QI Program:

(a) FCHPs, PCOs, DCOs and CDOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to OMAP Members. This process shall include an internal Quality Improvement (QI) program based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with relevant law and the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards. The QI program shall include policies, standards, and written procedures that adequately address the needs of OMAP Members, including those who are Aged, Blind, Disabled; or children receiving CAF (SOSCF) or OYA services. FCHPs, PCOs, DCOs and CDOs shall establish or adopt written criteria to monitor and evaluate the provision of adequate medical and/or dental care. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(b) MHOs shall abide by the Quality Assurance Requirements as stated in the MHO Agreement.

(2) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. FCHPs, PCOs, DCOs and CDOs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The Quality Improvement Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of OMAP Members including those who are Aged, Blind, Disabled and children receiving CAF (SOSCF) or OYA services, or shall be able to retain consultation from individuals who are qualified.

(3) FCHPs, PCOs, DCOs and CDOs shall establish a QI Committee that shall meet at least every two months; The Committee shall retain

authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:

(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings;

(b) Conduct and submit to OMAP an annual written evaluation of the QI Program and of OMAP Member care as measured against the written procedures and protocols of OMAP Member care. The evaluation of the QI program and OMAP Member care is to include a description of completed and ongoing QI activities, OMAP Member education and an evaluation of the overall effectiveness of the QI program. This evaluation shall include:

(A) Prevention programs;

(B) Care of OMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services, and FCHP or PCO review of the Quality of Exceptional Needs Care Coordination program;

(C) Disease management programs;

(D) Adverse outcomes of OMAP Members and OMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services;

(E) Actions taken by the FCHPs, PCOs, DCOs or CDOs to address health care concerns identified by OMAP Members or their Representatives and changes which impact quality or access to care. This may include: Clinical Record keeping; utilization review; referrals; comorbidities; prior authorizations; Emergency Services; out of FCHPs, PCOs, DCOs or CDOs utilization; medication review;

FCHPs, PCOs, DCOs or CDOs initiated Disenrollments; encounter data management; and access to care and services.

(c) Conduct a quarterly review and analysis of all Complaints and Appeals received including a focused review of any persistent and significant OMAP Member Complaints and Appeals;

(d) Review written procedures, protocols and criteria for OMAP Member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

(4) FCHPs or PCOs that are NCQA accredited or accredited by other OMAP recognized accreditation organizations shall be deemed for Section (3)(b) of this rule. FCHPs and PCOs deemed by OMAP shall annually submit to OMAP an evaluation of the Exceptional Needs Care Coordination program; and an evaluation of OMAP Member care for OMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services. Copies of accreditation reports shall be submitted to OMAP within 60 days of issuance.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
5-1-05

410-141-0220 Oregon Health Plan Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all Office of Medical Assistance Programs (OMAP) 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 OMAP Members and non-OMAP members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures which ensure that for 90% of their OMAP Members in each Service Area, routine travel time or distance to the location of the Primary Care Physician (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 OMAP:

(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 OMAP 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 OMAP Members in terms of timeliness, amount, duration and scope as those services are to non-OMAP persons within the same Service Area. If the PHP is unable to provide those services locally, it must so demonstrate to OMAP and shall provide reasonable alternatives for OMAP Members to access care that must be approved by OMAP. PHPs shall have a monitoring system that will demonstrate to OMAP or OMHAS, as applicable, that the PHP has surveyed and monitored for equal access of OMAP Members to referral Providers pharmacy, hospital, vision and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that OMAP Members who are Aged, Blind, or Disabled or who are children receiving Children, Adults and Families (CAF) State Office of Services to Children and Families (SOSCF) services or Oregon Youth Authority (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 OMAP Members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs and Primary Care Managers (PCMs) Enrollment Standards:

(a) PHPs and PCMs shall remain open for Enrollment unless DHS has closed Enrollment because the PHP or PCM has exceeded their Enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by OMAP or Office of Mental Health and Addiction Services (OMHAS), as appropriate, and the PHP or PCM;

(b) PHPs Enrollment may also be closed by OMAP or OMHAS, as appropriate due to sanction provisions;

(c) PHPs and PCMs shall accept all OHP Clients, regardless of health status at the time of Enrollment, subject to the stipulations in Contracts/agreements with DHS to provide covered services or Primary Care management services;

(d) PHPs and PCMs may confirm the Enrollment status of an OHP Client by one of the following:

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

(B) The individual presents a valid Medical Care Identification that shows he or she is enrolled with the PHP or PCM;

(C) The Automated Information System (AIS) verifies that the individual is currently eligible and enrolled with the PHP or PCM;

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

(e) PHPs shall have open Enrollment for 30 continuous calendar days during each twelve-month period of October through September, regardless of the PHP's 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, OMAP Members shall be automatically enrolled in the succeeding PHP. The OMAP Member will have 30 calendar days to request Disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare HMO, those OMAP 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 which has significant impact on access in that Service Area and necessitates either transferring OMAP Members to other Providers or the PHP withdrawing from part or all of a Service Area, the PHP shall provide DHS 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 days notice to DHS upon approval by DHS when the PHP must terminate a Participating Provider or Participating Provider group due to problems that could compromise OMAP 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 days notice;

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

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of OMAP 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 OMAP Members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

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

(ii) Urgent Care -- The OMAP Member shall be seen within 48 hours; and

(iii) Well Care -- The OMAP Member shall be seen within 4 weeks or within the Community Standard.

(B) DCOs:

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

(ii) Urgent Care -- The OMAP Member shall be seen within one to two weeks depending on OMAP Member's condition; and

(iii) Routine Care –The OMAP Member shall be seen for routine care within an average of eight (8) weeks and within twelve (12) weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(C) MHOs and CDOs:

(i) Emergency Care -- OMAP Member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care -- OMAP Member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care -- OMAP Member shall be seen for an intake assessment within 2 weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of OMAP Members through the office such that OMAP Members are not kept waiting longer than non-OMAP Member patients, under normal circumstances. If OMAP Members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, OMAP Members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through Complaint and Appeal reviews, OMAP termination reports, and OMAP 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 OMAP Member(s) when Participating Providers have notified the PHP that the OMAP Member(s) 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 OMAP 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 OMAP Members if there is a need to cancel or reschedule the OMAP 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 OMAP Members who walk to 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) OMAP Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the OMAP 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 OMAP and/or OMHAS 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 OMAP 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 OMAP 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 OMAP 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 OMAP 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 OMAP 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 OMAP 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 OMAP Members with hearing impairment or in the primary language of non-English

speaking OMAP Members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the OMAP Member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the Provider to be able to understand the OMAP Member's complaint; to make a diagnosis; respond to OMAP Member's questions and concerns; and to communicate instructions to the OMAP Member;

(c) PHPs shall ensure the provision of care and interpreter services, which 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 OMAP 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 OMAP 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 OMAP Members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of OMAP Members;

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

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

(ii) Wheelchair access to lavatory;

(iii) Wheelchair access to 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 special needs of OMAP Members who require accommodations because of a disability:

(A) PHPs shall have a written plan for meeting the needs of OMAP Members;

(B) PHPs shall monitor Participating Providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065

10-1-05

410-141-0260 Oregon Health Plan Prepaid Health Plan Complaint or Grievance and Appeal Procedures

(1) Definitions:

(a) Action - In the case of a PHP:

(A) The denial or limited authorization of a requested covered 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 OMAP;

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

(F) For an OMAP Member in a single PHP Service Area, the denial of a request to obtain covered services outside of the PHP's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(b) Appeal - A request by an OMAP Member or Representative for a PHP to review an "Action" as defined in this Section;

(c) Complaint - An OMAP Member's or OMAP Member's Representative's expression of dissatisfaction to a PHP or to a Practitioner about any matter other than an Action, as "Action" is defined in this section;

(d) Grievance System – The overall system that includes Complaints and Appeals handled at the PHP level, and access to the OMAP Administrative Hearing process.

(2) The purpose of OAR 410-141-0260 through 410-141-0266 is to describe the requirements for the overall Grievance System that includes

Complaint and Appeal procedures, which are handled at the PHP level, and that provides for access to the OMAP Administrative Hearing process. These rules will apply to all PHPs as defined in OAR 410-141-0000, excluding MHOs.

(3) All PHPs shall have written policies and procedures for a Grievance System that ensures that they meet the requirements of sections OAR 410-141-0260 to OAR 410-141-0266.

(4) Information provided to the OMAP Member shall include at least:

(a) Written material describing the PHP's Complaint and Appeal procedures, and how to make a Complaint or file an Appeal; and

(b) Assurance in all written, oral, and posted material of OMAP Member confidentiality in the Complaint and Appeal processes.

(5) An OMAP Member or an OMAP Member's Representative may file a Complaint and a PHP level Appeal orally or in writing, and may request an OMAP Administrative Hearing.

(6) PHPs shall keep all information concerning an OMAP Member's Complaint or Appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

(7) Consistent with confidentiality requirements, the PHP's staff person who is designated to receive Complaints or Appeals, shall begin to obtain documentation of the facts concerning the Complaint or Appeal upon receipt of the Complaint or Appeal.

(8) PHPs shall afford OMAP Members full use of the Grievance System procedures. If the OMAP Member decides to pursue a remedy through the OMAP Administrative Hearing process, the PHP will cooperate by providing relevant information required for the hearing process.

(9) A request for an OMAP Administrative Hearing made to OMAP outside of the PHP's Appeal procedures, or without previous use of the PHP's Appeal procedures shall be reviewed by the PHP through the PHP's

Appeal process upon notification by OMAP as provided for in OAR 410-141-0264.

(10) Under no circumstances may a PHP discourage an OMAP Member or an OMAP Member's Representative from using the OMAP Administrative Hearing process.

(11) 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 PHP for an OMAP member’s disenrollment.

(12) PHPs shall make available a supply of blank Complaint forms (OMAP 3001) in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to Complaints or Appeals. PHPs shall develop an Appeal form and shall make the forms available in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to Complaints or Appeals.

(13) The PHP must provide information about the Grievance System to all participating providers and subcontractors at the time they enter into a contract.

(14) The PHP must maintain logs that are in compliance with OAR 410-141-0266 to document Complaints and Appeals received by the PHP, and the State must review the information as part of the State quality strategy.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

410-141-0261 PHP Complaint Procedures

(1) A Complaint procedure applies only to those situations in which the OMAP Member or their representative expresses concern or dissatisfaction about any matter other than an “Action.” PHPs shall have written procedures to acknowledge the receipt, disposition and documentation of each Complaint from OMAP Members. The PHP’s written procedures for handling Complaints, shall, at a minimum:

(a) Address how the PHP will accept, process and respond to each Complaint from an OMAP Member or their Representative, including:

(A) Acknowledgment to the OMAP Member or representative of receipt of each Complaint;

(B) Ensuring that OMAP Members who indicate dissatisfaction or concern are informed of their right to file a Complaint and how to do so;

(C) Ensuring that each Complaint is transmitted timely to staff who have authority to act upon it;

(D) Ensuring that each Complaint is investigated and resolved in accordance with these rules; and

(E) Ensuring that the Practitioner(s) or staff person(s) who make decisions on the Complaint must be persons who are:

(F) Not involved in any previous level of review or decision-making; and

(G) Who are health care professionals who have appropriate clinical expertise in treating the OMAP Member’s condition or disease if the Complaint concerns denial of expedited resolution of an Appeal or if the Complaint involves clinical issues.

(b) Describe how the PHP informs OMAP Members, both orally and in writing, about the PHP’s Complaint procedures;

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

(d) Include a requirement for Complaints to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(2) The PHP must provide OMAP Members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a Complaint. This includes, but is not limited to, providing interpreter services and toll free phone numbers that have adequate TTY/TTD and interpreter capabilities.

(3) The PHP shall assure OMAP Members that Complaints are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the OMAP Member's right to confidentiality of information about the Complaint as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning an OMAP Member's Complaint is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any Practitioner whose services, items or quality of care is alleged to be involved in the Complaint have a right to use this information for purposes of the PHP resolving the Complaint, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes, without a signed release from the OMAP Member;

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the OMAP Member to authorize a release of information regarding the Complaint to other individuals as needed for resolution. Before any information related to the Complaint is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the Complaint file. Copies of the form for obtaining the release of information shall be included in the PHP's written process.

(4) The PHPs procedures shall provide for the disposition of Complaints within the following timeframes:

(a) The PHP must resolve each Complaint, and provide notice of the disposition, as expeditiously as the OMAP Member's health condition requires, within the timeframes established in this rule;

(b) For standard disposition of Complaints and notice to the affected parties, within 5 working days from the date of the PHP's receipt of the Complaint, the PHP must either:

(A) Make a decision on the Complaint and notify the OMAP Member; or

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

(5) The PHP's decision about the disposition of a Complaint shall be communicated to the OMAP Member orally or in writing within the timeframes specified in (4) of this rule:

(a) An oral decision about a Complaint shall address each aspect of the OMAP Member's Complaint and explain the reason for the PHP's decision;

(b) A written decision must be provided if the Complaint was received in writing. 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 PHP's decision.

(6) All Complaints made to the PHP's staff person designated to receive Complaints shall be entered into a log and addressed in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(7) All Complaints that the OMAP Member chooses to resolve through another process, and that the PHP is notified of, shall be noted in the Complaint log.

(8) OMAP Members who are dissatisfied with the disposition of a Complaint may present their complaint to the OMAP Ombudsman.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0262 PHP's Appeal Procedures

(1) The PHP must have a system in place for OMAP Members that includes an Appeal process. For purposes of this rule, an Appeal means a request to the PHP for review of an Action, as Action is defined in OAR 410-141-0260. An OMAP Member must complete the PHP's Appeal process before requesting an OMAP Administrative Hearing. If the OMAP Member initiates an Appeal, it shall be documented in writing by the PHP and handled as an Appeal.

(2) An Appeal must be filed with the PHP no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263.

(3) The OMAP Member or OMAP Member's Representative may file an Appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed Appeal.

(4) Each PHP must adopt written policies and procedures for handling Appeals that, at a minimum, meet the following requirements:

(a) Give OMAP Members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an Appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity;

(b) Address how the PHP will accept, process and respond to such Appeals, including how the PHP will acknowledge receipt of each Appeal;

(c) Ensuring that OMAP Members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an Appeal and how to do so;

(d) Ensuring that each Appeal is transmitted timely to staff who have authority to act on it;

(e) Ensuring that each Appeal is investigated and resolved in accordance with these rules; and

(f) Ensuring that the individuals who make decisions on Appeals are individuals:

(A) Who were not involved in any previous level of review or decision making; and

(B) Who are health care professionals who have the appropriate clinical expertise in treating the OMAP Member's condition or disease if an Appeal of a denial is based on lack of Medical Appropriateness or if an Appeal involves clinical issues.

(g) Include a requirement for Appeals to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(5) The PHP shall assure OMAP Members that Appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the OMAP Member's right to confidentiality of information about the Appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning an OMAP Member's Appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any Practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the Appeal have a right to use this information for purposes of resolving the Appeal and for purposes of maintaining the log required in OAR 410-141-0266 and for health oversight purposes by OMAP, without a signed release from the OMAP Member. The Administrative Hearing regarding the Appeal without a signed release from the OMAP Member, pursuant to OAR 410-120-1360 (4);

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the OMAP Member to authorize a release of information regarding the Appeal to other individuals. Before any information related to the Appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the Appeal file.

(6) The process for Appeals must:

(a) Provide that oral inquiries seeking to Appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the OMAP Member or OMAP Member's Representative requests expedited resolution;

(b) Provide the OMAP Member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the OMAP Member or the OMAP Member's Representative of the limited time available in the case of an expedited resolution);

(c) Provide the OMAP Member and/or the OMAP Member's Representative an opportunity, before and during the Appeals process, to examine the OMAP Member's file, including medical records and any other documents or records to be considered during the Appeals process; and

(d) Include as parties to the Appeal the OMAP Member, the OMAP Member's Representative, or the legal Representative of a deceased OMAP Member's estate;

(7) The PHP must resolve each Appeal and provide a client notice of the Appeal resolution as expeditiously as the OMAP Member's health condition requires and within the time frames in this section:

(a) For the standard resolution of Appeals and client notices to the OMAP

Member and/or OMAP Member's Representative, the PHP shall resolve the Appeal and provide a client notice no later than 45 calendar days from the day the PHP receives the Appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(b) When the PHP has granted a request for expedited resolution of an Appeal, the PHP shall resolve the Appeal and provide a client notice no later than 3 working days after the PHP receives the Appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(c) The PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:

(A) The OMAP Member requests the extension; or

(B) The PHP shows (to the satisfaction of OMAP, upon its request) that there is need for additional information and how the delay is in the OMAP Member's interest.

(d) If the PHP extends the timeframes, it must, for any extension not requested by the OMAP Member, give the OMAP Member a written notice of the reason for the delay.

(8) For all Appeals, the PHP must provide written Notice of Appeal Resolution to the OMAP Member or their Representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.

(9) The written Notice of Appeal Resolution must include the following:

(a) The results of the resolution process and the date it was completed; and

(b) For Appeals not resolved wholly in favor of the OMAP Member, the notice must also include the following information:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the Appeal;

(B) The right to request an OMAP Administrative Hearing, and how to do so, which includes attaching the "Notice of Hearing Rights (OMAP 3030) and the Hearing Request Form (AFS 443);

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(D) That the OMAP Member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.

(10) An OMAP Member may request an OMAP Administrative Hearing not later than 45 calendar days from the date on the PHP's Notice of Appeal Resolution, consistent with section (7)(a) of this rule. The parties to the OMAP Administrative Hearing include the PHP as well as the OMAP Member and/or OMAP Member's Representative, or the Representative of the deceased OMAP Member's estate.

(11) Each PHP shall establish and maintain an expedited review process for Appeals, consistent with OAR 410-141-0265.

(12) Each PHP shall maintain records of Appeals, enter Appeals and their resolution into a log, and address the Appeals in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(13) Continuation of benefits pending Appeal:

(a) As used in this section, "timely" filing means filing on or before the later

of the following:

(A) Within 10 calendar days of the PHP mailing the Notice of Action; or

(B) The intended effective date of the PHP's proposed Action.

(b) The PHP must continue the OMAP Member's benefits if:

(A) The OMAP Member or OMAP Member's Representative files the Appeal timely;

(B) The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(C) The services were ordered by an authorized Provider;

(D) The original period covered by the original authorization has not expired; and

(E) The OMAP Member requests extension of benefits.

(c) Continuation of benefits pending Administrative Hearing – If, at the OMAP Member's request, the PHP continues or reinstates the OMAP Member's benefits while the Appeal is pending and the Notice of Appeal Resolution is adverse to the OMAP Member, the benefits must be continued pending Administrative Hearing pursuant to OAR 410-141-0264.

(14) If the final resolution of the Appeal is adverse to the OMAP Member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the OMAP Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

(15) If the PHP, or an OMAP hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the OMAP Member's health condition requires.

(16) If the PHP, or the OMAP hearing decision reverses a decision to deny authorization of services, and the OMAP Member received the disputed services while the Appeal was pending, the PHP or OMAP must pay for the services in accordance with OMAP policy and regulations.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0263 Notice of Action by a Prepaid Health Plan

(1) When a PHP (or authorized Practitioner acting on behalf of the PHP) takes or intends to take any Action, including but not limited to denials or limiting prior authorizations of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other Action, the PHP (or authorized Practitioner acting on behalf of the PHP) shall mail a written client Notice of Action in accordance with section (2) of this rule to the OMAP Member within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be an OMAP approved format and it must be used for all denials of a requested covered service(s), reductions, discontinuations or terminations of previously authorized services, denials of claims payment, or other Action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the OMAP Member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) OMAP Member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service; and

(G) Effective date of the Action.

(b) The Action the PHP or its Participating Provider has taken or intends to take;

(c) Reasons for the Action, including but not limited to the following reasons:

(A) Treatment is not covered;

(B) The item requires pre-authorization and it was not pre-authorized;

(C) The service is not Dentally or Medically Appropriate;

(D) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(E) The person was not an OMAP Member at the time of the service or is not an OMAP Member at the time of a requested service; and

(F) The Provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan Rules).

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section, in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The OMAP Member's right to file an Appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The circumstances under which expedited Appeal resolution is available and how to request it;

(g) The OMAP Member's right to have benefits continue pending resolution of the Appeal, how to request that benefit(s) be continued, and the circumstances under which the OMAP Member may be required to pay the costs of these services; and

(h) The telephone number to contact the PHP for additional information.

(3) The PHP or Practitioner(s) acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension, or reduction of previously authorized OHP covered services, the following time frames apply:

(A) The notice must be mailed at least 10 calendar days before the date of Action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP (or authorized Practitioner acting on behalf of the PHP) may mail a notice not later than the date of Action if:

(i) The PHP or Practitioner receives a clear written statement signed by the OMAP Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The OMAP Member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The OMAP Member's whereabouts are unknown and the post office returns PHP or Practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another State, territory, or commonwealth has accepted the OMAP Member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the OMAP Member's PCP or PCD; or

(vi) The date of Action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5)(ii), related to discharges or transfers and long-term care facilities.

(C) The PHP may shorten the period of advance notice to 5 calendar days before the date of the Action if the PHP has facts indicating that an Action should be taken because of probable fraud by the OMAP Member.

Whenever possible, these facts should be verified through secondary sources.

(b) For denial of payment, at the time of any Action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the OMAP Member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the OMAP Member or the Provider requests the extension; or if the PHP justifies (to OMAP upon request) a need for additional information and how the extension is in the OMAP Member's interest;

(B) If the PHP extends the timeframe, in accordance with subsection (A) of this section, it must give the OMAP Member written notice of the reason for the decision to extend the timeframe and inform the OMAP Member of their right to file a Complaint if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the OMAP Member's health condition requires and no later than the date the extension expires.

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire;

(e) For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-05

410-141-0264 Administrative Hearings

(1) An individual who is or was an OMAP Member at the time of the Notice of Action is entitled to an Administrative Hearing by OMAP regarding the Notice of Appeal Resolution by a PHP that has denied requested services, payment of a claim, or terminates, discontinues or reduces a course of treatment, or any other Action. There is no right to a state administrative hearing based solely on a Notice of Action. The OMAP Member must go through the appeal process with their PHP before they can request a state administrative hearing. The decision in the Notice of Appeal Resolution is the document that will trigger the right to request a state administrative hearing. OMAP does not need to grant an Administrative Hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all OMAP Members. Client Administrative Hearings are governed by OAR 410-120-1860, 410-120-1865, and this rule.

(2) 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 Appeal Resolution.

(3) If, at the OMAP Member's request, the PHP continued or reinstated services while the Appeal was pending, the benefits must be continued pending the Administrative Hearing until one of the following occurs:

(a) The OMAP Member withdraws the request for an Administrative Hearing;

(b) Ten calendar days pass after the PHP mails the Notice of Appeal Resolution, providing the resolution of the Appeal against the OMAP Member, unless the OMAP Member within the 10-day timeframe, has requested an OMAP Administrative Hearing with continuation of benefits until the OMAP Administrative Hearing decision is reached;

(c) A final order is issued in an OMAP Administrative Hearing adverse to the OMAP Member; or

(d) The time period or service limits of a previously authorized service have been met.

(4) The OMAP Representative shall review the Administrative Hearing request, documentation related to the Administrative 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, and whether the hearing request was timely.

(5) PHPs shall immediately transmit to OMAP any Administrative Hearing request submitted on behalf of an OMAP Member, including a copy of the OMAP Member's Notice of Appeal Resolution.

(6) If the OMAP Member files a request for an Administrative Hearing with OMAP, OMAP will send a copy of the hearing request to the PHP.

(7) PHPs shall review an Administrative Hearing Request, which has not been previously received or reviewed as an Appeal, using the PHP's Appeal process as follows:

(a) The Appeal shall be reviewed immediately and shall be resolved, if possible, within 45 calendar days, pursuant to OAR 410-141-0262;

(b) The PHP's Notice of Appeal Resolution shall be in writing and shall be provide to the OMAP Member.

(8) When an Administrative Hearing is requested by an OMAP Member who has exhausted the PHP Appeal process, the PHP shall cooperate with providing relevant information required for the hearing process to OMAP, as well as the results of the review by the PHP of the Appeal and the Administrative Hearing request, and any attempts at resolution by the PHP.

(9) Information about OMAP Members used for Administrative Hearings is handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. OMAP will safeguard the OMAP Member's right to confidentiality of information used in the Administrative Hearing as follows:

(a) OMAP, the OMAP Member and their representative, the PHP and any Practitioner whose authorization, treatment, services, items, or request for payment is involved in the Administrative Hearing have a right to use this

information for purposes of resolving the Administrative Hearing without a signed release from the OMAP Member. OMAP may also use this information, pursuant to OAR 410-120-1360(4), for health oversight purposes, and for other purposes authorized or required by law. The information may also be disclosed to the Office of Administrative Hearings and the Administrative Law Judge assigned to the Administrative Hearing, and to the Court of Appeals if the OMAP Member seeks judicial review of the final order;

(b) Except as provided in subsection (a), OMAP will ask the OMAP Member to authorize a release of information regarding the Administrative Hearing to other individuals. Before any information related to the Administrative Hearing is disclosed under this subsection, OMAP must have an authorization for release of information documented in the Administrative Hearing file.

(10) The hearings request (AFS 443), along with the Notice of Appeal Resolution, shall be referred to the Office of Administrative Hearings and the hearing will be scheduled.

(a) The parties to the Administrative Hearing shall include the PHP, as well as the OMAP Member and his or her Representative, or the Representative of a deceased OMAP Member’s estate;

(b) The procedures applicable to the Administrative Hearing shall be conducted consistent with OAR 410-120-1860 and OAR 410-120-1865;

(c) A final order should be issued or the case otherwise resolved by OMAP not later than 90 calendar days following OMAP's receipt of the request for Administrative Hearing. Delay due to a postponement or continuance granted at the request of a party or OMAP, or with the consent of the parties or OMAP, shall not be counted in computing the time limit. The final order is the final decision of OMAP.

(11) If the final resolution of the Administrative Hearing is adverse to the OMAP Member, that is, if the final order upholds the PHP’s Action, the PHP may recover the cost of the services furnished to the OMAP Member while the Administrative Hearing is pending, to the extent that they were

furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 438.420.

(12) The PHP must promptly correct the Action taken up to the limit of the original request or authorization, retroactive to the date the Action was taken, if the hearing decision is favorable to the OMAP Member, or OMAP and/or the PHP decides in the OMAP Member's favor before the hearing even if the OMAP Member has lost eligibility after the date the Action was taken:

(a) If the PHP, or an OMAP hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the Administrative Hearing was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the OMAP Member’s health condition requires;

(b) If the PHP, or the OMAP hearing decision reverses a decision to deny authorization of services, and the OMAP Member received the disputed services while the Administrative Hearing was pending, the PHP must pay for the services in accordance with OMAP policy and regulations in effect when the request for services was made by the OMAP Member.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0265 Request for Expedited Appeal or Expedited Administrative Hearing

(1) Each PHP shall establish and maintain an expedited review process for Appeals, when the PHP determines (upon request from the OMAP Member) or the Provider indicates (in making the request on an OMAP Member's behalf or supporting the OMAP Member's request) that taking the time for a standard resolution could seriously jeopardize the OMAP Member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports an OMAP Member's Appeal.

(3) If the PHP provides an expedited Appeal, but denies the services or items requested in the expedited Appeal, the PHP shall inform the OMAP Member of the right to request an expedited Administrative Hearing and shall provide the OMAP Member with a copy of both the AFS Form 443 and Notice of Hearing Rights (OMAP 3030) with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on Appeal, it must:

(a) Transfer the Appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the OMAP Member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) An OMAP Member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the OMAP Member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to OMAP's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. OMAP's Medical

Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether that OMAP Member is entitled to an expedited Administrative Hearing.

(7) If the OMAP Medical Director denies a request for expedited Administrative Hearing, OMAP must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the OMAP Member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0266 The PHP's Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The PHP's documentation shall include, at minimum, a log of all oral and written Complaints and Appeals received by the PHP. The log shall identify the OMAP Member and the following additional information:

(a) For Complaints, the date of the Complaint, the nature of the Complaint, the disposition and date of disposition of the Complaint;

(b) For Appeals, the date of the Notice of Action, the date of the Appeal, the nature of the Appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the Appeal. If an Administrative Hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the Administrative Hearing.

(2) The PHP shall also maintain a record for each of the Complaints and Appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the OMAP Member. The PHPs shall retain documentation of Complaints and Appeals for the term of the OHP Demonstration Project plus two years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the Grievance System, including all Complaints and Appeals received by the PHP. The analysis of the Grievance System shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of Complaints and Appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of Complaints and Appeals, and compliance with Oregon Health Plan rules.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0270 Oregon Health Plan Marketing Requirements

(1) PHPs may not conduct, directly or indirectly, door-to-door, telephonic, electronic, mail or other cold call marketing practices to entice OHP Clients to enroll into their PHP.

(2) PHPs or their subcontractors shall not seek to influence OHP Client's Enrollment with the PHP. PHPs are allowed to engage in activities for purposes of outreach to existing OMAP Members, health promotion and health education.

(3) Any written communication by the PHP or its subcontractors and providers which is intended solely for OMAP Members and pertains to provider requirements for obtaining services, care at service sites, or benefits, must be approved by OMAP and/or OMHAS prior to distribution.

(4) PHPs may also communicate with providers, caseworkers, community agencies and other interested parties for informational purposes. The intent of these communications should be informational and not to entice or solicit membership. Communication methodologies may include, but are not limited to;

(A) Brochures, pamphlets, newsletters, posters, fliers, web sites, health fairs, or sponsorship of health-related events;

(B) The creation of name recognition, as a result of PHP's health promotion or education activities, shall not be deemed to constitute an attempt by PHPs to influence a OHP Client's Enrollment;

(C) PHP shall cooperate in developing a comprehensive explanation of the services available from PHP under Contract/Agreement with DHS for the OMAP Comparison Charts;

(5) Subcontractors may post a sign listing all OHP PHPs to which the provider belongs and display PHP -sponsored health promotional materials.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065

410-141-0280 Oregon Health Plan Prepaid Health Plan Informational Requirements

(1) Prepaid Health Plans (PHPs) shall develop informational materials for Potential Office of Medical Assistance Programs (OMAP) Members:

(a) PHPs shall provide OMAP and/or Office of Mental Health and Addiction Services (OMHAS) with informational materials sufficient for the potential OMAP Member to make an informed decision about PHP selection and Enrollment. Information on Participating Providers must be made available from the PHP, upon request to Potential OMAP Members, and must include Participating Providers' name, location, qualification and the availability of the PCP, clinic and specialists. Informational materials may be included in the application packet for Potential OMAP Members;

(b) PHPs shall ensure that all PHP's staff who have contact with Potential OMAP Members are fully informed of PHP and OMAP and/or OMHAS policies, including Enrollment, Disenrollment, Complaint and Grievance policies and the provision of interpreter services including which Participating Providers' offices have bilingual capacity;

(c) PHPs shall cooperate and provide accurate information to OMAP for the updating of the comparison charts.

(2) Informational materials that PHPs develop for OMAP Members and Potential OMAP Members shall meet the language requirements of, and be culturally sensitive to the PHP's OMAP membership including members with disabilities or reading limitations, and including substantial populations whose primary language is not English in its particular Service Area(s)

(a) PHPs shall be required to follow OMAP's substantial household criteria required by ORS 411.062, which determines and identifies those populations that are considered non-English speaking households; however, PHP shall only be responsible for those identified languages, if the substantial population is 35 or more non-English speaking households with the same language in its Service Area. The PHP shall be required to provide informational materials,

which at a minimum, shall include the OMAP Member handbook and information about Complaints and Appeals in the primary language of each substantial population. Alternative forms may include, but are not limited to audio tapes, close-captioned videos, large type and Braille;

(b) Form correspondence sent to OMAP Members, including but not limited to, Enrollment information, choice and OMAP Member counseling letters and denial of service notices shall include instructions in the appropriate languages of each substantial population of non-English speaking OMAP Members on how to receive an oral translation of the material;

(c) All written informational materials distributed to OMAP Members shall be written at the sixth grade reading level and printed in 12 point print or larger;

(d) PHPs shall provide written notice to affected OMAP Members of any significant changes in program or service sites that impacts the OMAP Members' ability to access care or services from PHP's Participating Providers. Such notice shall be provided at least 30 calendar days prior to the effective date of that change, or as soon as possible if the Participating Provider(s) has not given the PHP sufficient notification to meet the 30 days notice requirement. OMAP and/or OMHAS will review and approve such materials within two working days.

Stat. Auth.: ORS 409

Stats. Implemented: 414.725
5-1-05

410-141-0300 Oregon Health Plan Prepaid Health Plan Member Education

CDO: Chemical Dependency Organization

DCO: Dental Care Organization

DHS: Department of Human Services

ENCC: Exceptional Needs Care Coordination

FCHP: Fully Capitated Health Plan

MHO: Mental Health Organization

PCD: Primary Care Dentist

PCO: Physican Care Organization

PCP: Primary Care Provider

PHP: Prepaid Health Plan (FCHP, PCO, DCO, CDO and MHO) OHP: Oregon Health Plan OMHAS: Office of Mental Health and Addiction Services OMAP: Office of Medical Assistance Programs

(1) PHPs shall have an ongoing process of OMAP Member education and information sharing that includes orientation to the PHP, a PHP OMAP Member handbook and health education. OMAP Member education shall include: (a) The availability of ENCC through FCHPs and PCOs for OMAP Members with special health care needs, who are Aged, Blind or Disabled; and

(b) The appropriate use of the delivery system, including a proactive and effective education of OMAP Members on how to access Emergency Services and Urgent Care Services appropriately.

(2) PHPs shall offer PHP orientation to new OMAP Members by mail, phone, or in person within 30 days of Enrollment unless no address can be obtained, a telephone number is not provided by OMAP, and a DHS agency is unable to assist in delivering the information to the OMAP Member.

(3) PHP OMAP Member handbook materials:

(a) The PHP OMAP Member handbook shall be made available for new OMAP Members, as described in OAR 410-141-0280, Oregon Health Plan PHP Informational Requirements, and shall be distributed within 14 calendar days of the OMAP Member's effective date of coverage with PHP;

(b) At a minimum the information in the PHP OMAP Member handbook shall contain the following elements:

(A) Location(s), office hours and availability of physical access for OMAP Members with disabilities to PHP and PCP and PCD offices;

(B) Telephone number(s) (including TTY) for OMAP Members to call for more information and telephone numbers relating to information listed below;

(C) OMAP Member’s choice and use of PCPs, PCDs and policies on changing PCPs, PCDs;

(D) Use of the PHP’s appointment system;

(E) Use of the PHP’s referral system, including procedures for obtaining benefits, including authorization requirements;

(F) How OMAP Members are to access Urgent Care Services and advice;

(G) How and when OMAP Members are to use Emergency Services including information on Post-Stabilization Care Services, related to an emergency medical condition that are provided after an OMAP Member is stabilized in order to maintain the stabilized condition, or, under the circumstances to improve or resolve the OMAP Member's condition;

(H) Information on the PHP's Complaint process and information on fair hearing procedures;

(I) How OMAP Members are to access interpreter services including sign interpreters;

(J) Information on the OMAP Member’s rights and responsibilities;

(K) Information on the OMAP Member's possible responsibility for charges including Medicare deductibles and coinsurances (if they go outside of PHP for non-emergent care), co-payments, and charges for non-covered services;

(L) The transitional procedures for new OMAP Members to obtain prescriptions, supplies and other necessary items and/or services in the first month of Enrollment with the PHP if they are unable to meet with a PCP, PCD, other prescribing Practitioner or obtain new orders during that period;

(M) What services can be self-referred to both Participating and Non-Participating Providers (FCHPs, PCOs and MHOs only);

(N) To adult OMAP Members written information on Advance Directive policies including:

(i) A description of applicable state law;

(ii) OMAP Member rights under Oregon law;

(iii) The contractor’s policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(O) How to request information on the PHP’s Physician Incentives;

(P) The OMAP Members right to request and obtain copies of their Clinical Records (and that they may be charged a reasonable copying fee) and to request that the record be amended or corrected;

(Q) How OMAP Members are to obtain emergent and non-emergent ambulance services (FCHP and PCO only) and other medical transportation to appointments, as appropriate;

(R) Explanation of the amount, scope and duration of covered and Non-covered Services in sufficient detail to ensure that OMAP Members understand the benefits to which they are entitled;

(S) How OMAP Members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs (FCHPs and PCOs only);

(T) PHP’s Confidentiality Policy;

(U) Name, locations, telephone numbers of, and non-English languages offered by current Participating Providers, including information on PHP’s PCPs/PCDs that are not accepting new OMAP Members (not MHOs) including at a minimum, information on PCPs, specialists and hospitals in the OMAP Member’s Service Area;

(V) The extent to which; and how, OMAP Members may obtain benefits, including family planning services, from out of network Providers;

(W) Any restrictions on the OMAP Member’s freedom of choice among network Providers;

(X) Policies on referrals for specialty care and for other benefits not furnished by the OMAP Member’s PCP;

(Y) How and where OMAP Members are to access any benefits that are available under OHP but are not covered under the PHPs’ Contract, including any cost sharing, and how transportation is provided.

(c) If the PHP OMAP Member handbook is returned with a new address, the PHP shall re-mail the PHP OMAP Member handbook or use the telephone number provided by DHS to reach the OMAP Member. If the PHP is unable to reach the OMAP Member by either mail or telephone, the PHP shall retain the PHP OMAP Member handbook and have it available upon request for the OMAP Member;

(d) PHPs shall, at a minimum, annually and upon request provide the PHP OMAP Member handbook to OMAP Members, OMAP Member’s Representative and to clinical offices for distribution to OMAP Members;

(e) The PHP OMAP Member handbook shall be reviewed by PHP for accuracy at least yearly and updated with new or corrected information as needed to reflect the PHP's internal changes and regulatory changes. If changes impact the OMAP Members' ability to use services or benefits, the updated materials shall be distributed to all OMAP Members;

(f) The DHS "Oregon Health Plan Client Handbook" is in addition to the PHP OMAP Member handbook and cannot be used to substitute for the PHP OMAP Member handbook.

(4) PHPs shall have written procedures and criteria for health education of OMAP Members. Health education shall include: information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. Health education may be provided by PHP's Practitioner(s) or other individual(s) or program(s) approved by the PHP. PHPs shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures: PHPs shall ensure development and maintenance of an individualized health educational plan for OMAP Members who have been identified by their Practitioner as requiring specific educational intervention. DHS may assist in developing materials that address specifically identified health education problems to the population in need.

(5) PHPs shall provide an identification card to OMAP Members, unless waived by OMAP and/or OMHAS, which contains simple, readable and usable information on how to access care in an urgent or emergency situation. Such identification cards shall confer no rights to services or other benefits under the Oregon Health Plan and are solely for the convenience of the PHP's, OMAP Members and Providers.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

10-1-05

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 OMAP 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 OMAP Member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) OMAP 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 or PCM 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 his/her treatment plan;

(g) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(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 OMAP Member;

(k) To receive necessary and reasonable services to diagnose the presenting condition;

(l) To receive covered services under the Oregon Health Plan which 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, 7 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 which documents conditions, services received, and referrals made;

(q) To have access to one's own clinical record, unless restricted by statute;

(r) To transfer of a copy of his/her 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 – 410-141-0266;

(v) To request an Administrative Hearing with the Department of Human Services;

(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) OMAP Members shall have the following responsibilities:

(a) To choose, or help with assignment to, a PHP or PCM as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements, and a PCP or service site;

(b) To treat the PHP's, practitioner's, and clinic's 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 he/she expects to be late;

(d) To seek periodic health exams and preventive services from his/her PCP or clinic;

(e) To use his/her 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 which may include signing an authorization for release of information;

(j) To ask questions about conditions, treatments and other issues related to his/her 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 his/her health care is covered under the Oregon Health Plan before services are received and, if requested, to show the practitioner or other provider the OMAP Medical Care Identification form;

(o) To tell the DHS worker of a change of address or phone number;

(p) To tell the DHS worker if the OMAP Member becomes pregnant and to notify the DHS worker of the birth of the OMAP Member's child;

(q) To tell the DHS worker if any family members move in or out of the household;

(r) To tell the DHS 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 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 DHS and the PHP can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
5-1-05

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/agreements with OMAP and/or OMHAS. PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to OMAP and/or OMHAS, as applicable:

(a) PHPs shall comply with solvency requirements specified in Contracts/agreements with OMAP and/or OMHAS, as applicable. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in Contracts/agreements with OMAP and/or OMHAS. If the PHP has Contracts/agreements with both OMAP and OMHAS, separate restricted reserve fund accounts shall be maintained for each Contract/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 OMAP and/or OMHAS, as applicable. Self-insurance must be determined appropriate by OMAP and/or OMHAS;

(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 OMAP Members and accounting for Capitation Payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of OMAP Members; and

(vi) Documention 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 OMAP and/or OMHAS:

(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 Sheet(s);

(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 OMAP and/or OMHAS.

(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/hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (OMHAS contractors); and

(viii) Corporate Relationships of Contractors (FCHPs, DCOs, CDOs 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, DCOs and CDOs 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 which is covered by any identified risk-adjustment mechanisms.

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

(a) MHOs that subcapitate any work described in agreements with OMHAS 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 OMHAS. Regardless of the alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with OMHAS;

(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 OMHAS, the MHO shall provide advance notice to OMHAS 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 OMHAS access to restricted reserve funds if insolvency occurs;

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

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
5-1-05

410-141-0400 Oregon Health Plan Prepaid Health Plan Case Management Services

DCO: Dental Care Organization

FCHP: Fully Capitated Health Plan

MHO: Mental Health Organization

OHP: Oregon Health Plan

PCO: Physician Care Organization

PHP: Prepaid Health Plan

(1) Prepaid Health Plans provide Case Management Services under the Oregon Health Plan.

(2) Prepaid Health Plan Case Management Services are defined as follows:

(a) FCHPs and PCOs provide Medical Case Management as defined in OAR 410-141-0000, Definitions;

(b) DCOs provide Dental Case Management as defined in OAR 410-141-0000, Definitions. DCOs shall make Dental Case Management staff available for training, Regional OHP meetings, and case conferences involving their OMAP Members in all service areas; (c) MHOs provide Mental Health case management for capitated and non-capitated mental health services as defined in OAR 410-141-0000, Definitions.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
5-1-05

410-141-0405 Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination (ENCC)

Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

(1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all Capitated Services;

(2) FCHPs and PCOs shall make ENCC services available at the request of the Aged, Blind or Disabled OMAP Member, his or her Representative, a physician, or other medical personnel serving the OMAP Member, or the Aged, Blind or Disabled OMAP Member's agency case manager;

(3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving their Aged, Blind and Disabled OMAP Members in all their Service a Areas;

(4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are Aged, Blind, Disabled or have special health care needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;

(5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs and PCOs shall make ENCC services available to OMAP Members who are Aged, Blind, Disabled or having special health care needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to an OMAP Member’s Representative during normal business hours, Monday through Friday;

(7) FCHPs and PCOs shall provide the Aged, Blind, Disabled or special health care need OMAP Member or his or her Representative

who requests ENCC services with an initial response by the next working day following the request, as appropriate;

(8) FCHPs and PCOs shall periodically inform all of their Practitioners and the Practitioner’s staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving the Aged, Blind, Disabled or special need OMAP Members; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and OMAP Members or their Representatives;

(9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of covered services to Aged, Blind, Disabled or special need OMAP Members who exhibit inappropriate, disruptive or threatening behaviors in a Practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in OMAP Member medical records as appropriate and/or in a separate OMAP Member case file.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
5-1-05

410-141-0407 Oregon Health Plan Ombudsman Services

(1) Department of Human Services (DHS) provides Ombudsman services for Aged, Blind and Disabled Oregon Health Plan clients and OMAP Members as defined in OAR 410-141-0000, Definitions.

(2) Department of Human Services (DHS) shall inform all Aged, Blind and Disabled Oregon Health Plan clients and OMAP Members of the availability of Ombudsman Services.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725

10-1-03

410-141-0410 Oregon Health Plan Primary Care Managers

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

(a) Preventive services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, federally qualified health centers, county health departments, Indian health service clinics, and tribal health clinics;

(b) Inpatient hospital services;

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

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

(a) Anesthesiology services;

(b) Dental care services;

(c) Durable medical equipment;

(d) Family planning services;

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

(f) Laboratory services;

(g) Maternity Case management services;

(h) Medical transportation services;

(i) Mental health and chemical dependency services;

(j) Pharmacy services;

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

(l) Preventive services for acquired immune deficiency syndrome and

human immuno-deficiency virus;

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

(n) School-based services provided under an Individual Education Plan or an Individual Family Service Plan;

(o) Targeted case management services;

(p) Diagnostic Imaging.

Stat. Auth.: ORS 409

Stats. Implemented: 414.725

10-1-04

410-141-0420 Oregon Health Plan Prepaid Health Plan Billing and Payment Under the Oregon Health Plan

(1) All billings for Oregon Health Plan Clients to Prepaid Health Plans (PHPs) and to Office of Medical Assistance Programs (OMAP) shall be submitted within four (4) months and twelve (12) months, respectively, of the date of service, subject to other applicable OMAP billing rules. Submissions shall be made to PHPs within the four (4) month time frame except in the following cases:

(a) Pregnancy;

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

(c) Medicare is the primary payor;

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

(e)Third Party Resource (TPR). Pursuant to 42 CFR 36.61, 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 payor of last resort and is not considered an alternative resource or TPR.

(2) Providers must be enrolled with OMAP to be eligible for Fee-for-Service (FFS) payment by OMAP. Mental health Providers, except Federally Qualified Health Centers, must be approved by the Local Mental Health Authority (LMHA) and the Office of Mental Health and Addiction Services (OMHAS) before enrollment with OMAP. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260, Provider enrollment.

(3) Providers, including mental health Providers, do not have to be enrolled with OMAP to be eligible for payment for services by PHPs except that Providers who have been excluded as Medicare/Medicaid Providers by OMAP, CMS or by lawful court orders are ineligible to receive payment for services by PHPs.

(4) Providers shall verify, before rendering services, that the OMAP Member is eligible for the Medical Assistance Program on the date of service and that the service to be rendered is covered under the Oregon Health Plan Benefit Package of Covered Services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorizations from the appropriate payor before rendering services. Providers shall inform OMAP Members of any charges for non-covered services prior to the services being delivered.

(5) Capitated Services:

(a) PHPs receive a Capitation Payment to provide services to OMAP Members. These services are referred to as Capitated Services;

(b) PHPs are responsible for payment of all Capitated Services. Such services should be billed directly to the PHP, unless the PHP or OMAP specifies otherwise. PHPs may require Providers to obtain preauthorization to deliver certain Capitated Services.

(6) Payment by the PHP to Providers for Capitated Services is a matter between the PHP and the Provider, except as follows:

(a) Pre-authorizations:

(A) PHPs shall have written procedures for processing pre-authorization requests received from any Provider. The procedures shall specify time frames for:

(i) Date stamping pre-authorization requests when received;

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

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

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

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

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

(B) PHPs shall make a determination on at least 95% of Valid Pre-Authorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in a skilled nursing facility. Pre-authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If a pre-authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHP shall notify Providers of such determination within 2 working days of receipt of the request;

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

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

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

(D) For all other pre-authorization requests, PHPs shall notify Providers of an approval, a denial or a need for further information within 14 calendar days of receipt of the request. PHPs must make reasonable efforts to obtain the necessary information during that 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information, if the PHP justifies the need for additional information and how the delay is in the interest of the OMAP Member. The PHP shall make a determination as the OMAP Member's health condition requires, but no later than the expiration of the extension. PHPs shall notify OMAP Members of a denial within

five working days from the final determination using an OMAP or OMHAS approved client notice format.

(b) Claims Payment:

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

(i) Date stamping claims when received;

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

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

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

(v) Sending notice of the decision with Appeal rights to the OMAP Member when the determination is made to deny the claim.

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

(C) PHPs shall provide written notification of PHP determinations when such determinations result in a denial of payment for services, for which the OMAP Member may be financially responsible. Such notice shall be provided to the OMAP Member and the treating Provider within 14calendar days of the final determination. The notice to the OMAP Member shall be an OMAP or OMHAS approved notice format and shall include information on the PHPs internal appeals process, and the Notice of Hearing Rights (OMAP 3030) shall be attached. The notice to the Provider shall include the reason for the denial;

(D) PHPs shall not require Providers to delay billing to the PHP;

(E) PHPs shall not require Medicare be billed as the primary insurer for services or items not covered by Medicare, nor require non-Medicare approved Providers to bill Medicare;

(F) PHPs shall not deny payment of Valid Claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the OMAP Member's Clinical Record;

(G) PHPs shall not delay nor deny payments because a co-payment was not collected at the time of service.

(c) FCHPs, PCOs, and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the OMAP Member receives within the PHP, for authorized referral care, and for Urgent Care Services or Emergency Services the OMAP Member receives from non-contracted Providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care OMAP Members receive from Non Participating Providers-;

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

(e) PHPs shall be responsible for payment of covered services provided by a Non-Participating Provider that were not pre-authorized 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 pre-authorized with a Participating Provider if the PHP's referral protocols had been followed;

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

(7) Other Services:

(a) OMAP Members enrolled with PHPs may receive certain services on an OMAP FFS basis. Such services are referred to as Non-Capitated Services;

(b) Certain services must be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though such services are then paid by OMAP on an OMAP FFS basis. Before providing services, Providers should contact the PHPs identified on the OMAP Member's Medical Care Identification or, for some mental health services, the CMHP. Alternatively, the Provider may call the OMAP Provider Services Unit to obtain information about coverage for a particular service and/or pre-authorization requirements;

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

(d) Providers shall bill OMAP directly for Non-Capitated Services in accordance with billing instructions contained in the OMAP administrative rules and supplemental information;

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

(f) OMAP will not pay a Provider for provision of services for which a PHP has received a Capitation Payment unless otherwise provided for in OAR 410-141-0120;

(g) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of OMAP, OMHAS, nor a PHP except as provided for in OMAP administrative rules and supplemental information (e.g., Capitated Services that are not included in the nursing facility all-inclusive rate);

(h) FCHPs and PCOs that contract with non-public teaching hospitals will reimburse those hospitals for Graduate Medical Education (GME), if the hospitals are:

(A) Neither a type A nor type B hospitals;

(B) Not paid according to a type A or type B payment methodology; and,

(C) In remote areas greater than 60 miles from the nearest acute care hospital, with a graduate medical student teaching program.

(i) 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 which the FCHP or PCO would make for the same service(s) furnished by a Provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

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

(9) OHP Clients who are enrolled with a PCM receive services on a FFS basis:

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

(b) PCMs provide Primary Care access, and management services for Preventive Services, primary care services, referrals for specialty

services, limited inpatient hospital services and outpatient hospital services. OMAP payment for these PCM managed services is contingent upon PCCM authorization;

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

(d) OMAP shall pay at the OMAP Fee-For-Service (FFS) rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate OMAP administrative rules and supplemental information.

(10) All OHP Clients who are enrolled with a PCO receive inpatient hospital services on an OMAP FFS basis:

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

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

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

(11) OHP Clients who are not enrolled with a PHP receive services on an OMAP FFS basis:

(a) Services may be received directly from any appropriate enrolled OMAP Provider;

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

(c) OMAP shall pay at the OMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in

the appropriate OMAP administrative rules and supplemental information.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

10-1-05

410-141-0440 Prepaid Health Plan Hospital Contract Dispute Resolution

When there is a failure to reach agreement on a contract between a Fully Capitated Health Plan (FCHP) or a Physician Care Organization (PCO) and a non Type A, Type B, or Critical Access hospital, the two disagreeing parties must engage in non-binding mediation. This requirement to engage in non-binding mediation does not apply to disagreements involving emergency or urgent services as defined in Oregon Health Plan Administrative Rules. Either the hospital, FCHP, or the PCO can call for mediation. If the parties agree on a mediator their selection shall stand. If a mediator cannot be mutually agreed on, the State will make the selection from the recommended names forwarded by each party. The cost of mediation will be evenly split between the FCHP or PCO and the hospital.

(1) The mediation will proceed under the following guidelines:

(a) Access to care for Oregon Health Plan Members is of critical importance;

(b) Any agreement must operate within the capitation rate received by the FCHP or PCO;

(c) Reimbursement levels must bear some relationship to the cost of the services;

(d) Consideration shall be given to the efforts of each part to manage the overall utilization of health care resources and control costs;

(e) A comparison to statewide averages of each party's cost of services, service utilization rates and administrative costs may be considered in reaching a mediation recommendation.

(2) No client medical information, communication between parties, nor any other non public information used in the mediation may be disclosed to any person not a party to the mediation. All such information shall not be admissible nor disclosed in any subsequent administrative, judicial or mediation proceeding.

(3) Within thirty (30) days of the conclusion of the mediation, the mediator will issue a report to the State and to the involved parties that will include mediation findings, and recommendations. All confidential information will be excluded from the mediator's report.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
5-1-05

410-141-0480 Oregon Health Plan Benefit Package of Covered Services

(1) OMAP Members are eligible to receive, subject to Section (11) of this rule, those treatments for the condition/treatment pairs funded on the Oregon Health Services Commission's Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are Medically or Dentally appropriate, except that services must also meet the prudent layperson standard defined in OAR 410-141-0140. Refer to 410-141-0520 section (4) for funded line coverage information.

(2) Medical Assistance Benefit Packages follow practice guidelines adopted by the Health Services Commission (HSC) in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.

(3) Diagnostic Services that are necessary and reasonable to diagnose the presenting condition of the OMAP Member are covered services, regardless of the placement of the condition on the Prioritized List of Health Services.

(4) Comfort care is a covered service for an OMAP Member with a Terminal Illness.

(5) Preventive Services promoting health and/or reducing the risk of disease or illness are covered services for OMAP Members. Such services include, but are not limited to, periodic medical and dental exams based on age, sex and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors, (See Prioritized List of Health Services, adopted in OAR 410-141-0520).

(6) Ancillary Services are covered, subject to the service limitations of the Medical Assistance Program rules, when the services are Medically or Dentally Appropriate for the treatment of a covered condition-treatment pair, or the provision of ancillary services will enable the OMAP Member to retain or attain the capability for independence or self-care. A list of Ancillary Services is included in the Prioritized List of Health Services, adopted in OAR 410-141-0520.

(7) The provision of Chemical Dependency Services must be in compliance with the Office of Mental Health and Addiction Services (OMHAS) Administrative Rules, OAR 415-020-0000 to 0090 and 415-051-0000 to 0130 and the requirements in the Chemical Dependency subsection of the Statement of Work in the Fully Capitated Health Plan and Physician Care Organization contracts.

(8) In addition to the coverage available under section (1) of this rule, an OMAP Member may be eligible to receive, subject to section (12), services for treatments which are below the funded line or not otherwise excluded from coverage:

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

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

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

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

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

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

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

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any OMAP Member, especially an OMAP Member with a disability or with a comorbid condition, Providers must determine whether the OMAP Member has a funded condition and paired treatment that would entitle the OMAP Member to treatment under the program and both the funded and unfunded conditions must be represented by an ICD-9-CM diagnosis code; or, when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity.

(9) OMAP shall maintain a telephone information line for the purpose of providing assistance to Practitioners in determining coverage under the Oregon Health Plan Benefit Package of covered services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, OMAP shall make a retrospective determination under this subsection, provided OMAP is notified of the emergency situation during the next business day. If OMAP denies a requested service, OMAP shall provide written notification and a notice of the right to an Administrative Hearing to both the OHP Client and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the Health Services Commission's list of prioritized services and OMAP determines the condition/treatment pair has not been identified by the Commission for inclusion on the list, OMAP shall make a coverage decision in consultation with the Health Services Commission.

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

(12) General anesthesia for dental procedures which are Medically and/or Dentally Appropriate to be performed in a hospital or ambulatory surgical setting, is to be used only for those OMAP Members with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure as outlined below:

(a) Children under three years old with dental needs determined by the dentist or oral surgeon as requiring general anesthesia;

(b) Children over three years old requiring substantial dental care determined by the dentist or oral surgeon as requiring general anesthesia that may protect the child from unnecessary trauma;

(c) OMAP Members with physical, mental or medically compromising conditions;

(d) OMAP Members with dental needs for who local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;

(e) Acute situational anxiety, fearfulness, extremely uncooperative or uncommunicative client with dental needs, determined by the dentist or oral surgeon, sufficiently important that dental care cannot be deferred;

(f) OMAP Members who have sustained extensive orofacial and dental trauma; or

(g) OMAP Members with dental needs who otherwise would not obtain necessary dental care when, in the decision of the dentist or oral surgeon, the need for dental treatment outweighs the risks of general anesthesia. The OMAP Member's dental record must clearly document the justification for the level of anesthesia and why, in the estimation of the dentist or oral surgeon, the treatment in an office setting is not possible.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

5-1-05

410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients and or OMAP Members

(Effective for services rendered on or after October 1, 2003.)

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan;

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the Oregon Health Plan Administrative Rules;

(c) Any treatment, service, or item for a condition that is not included on the funded lines of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the OHP Client's and/or OMAP Member's OHP benefit package, are excluded;

(e) Any treatment, service, or item for a condition which is listed as a Condition / Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or non-covered condition/ treatment pair;

(g) Services requested by Oregon Health Plan (OHP) Clients and/or OMAP Member's in an emergency care setting which after a screening examination are determined not to meet the definition of Emergency Services and the provisions of 410-141-0140;

(h) Services provided to an Oregon Health Plan Client and/or OMAP Member outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(i) Services or items, other than inpatient care, provided to an Oregon Health Plan Client and/or OMAP Member who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080 (2)(b)(G);

(j) Services received while the OMAP Member is outside the Contractor's Service Area that were either:

(A) Not authorized by the OMAP Member's Primary Care Provider; or

(B) Not urgent or Emergency Services, subject to the OMAP Member's Appeal rights, that the OMAP Member was outside Contractor's Service Area because of circumstances beyond the OMAP Member's control. Factors to be considered include but are not limited to death of a family member outside of Contractor's Service Area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are Medically Appropriate to provide reasonable diagnosis and treatment or to enable the Oregon Health Plan Client to attain or retain the capability for independence or self-care. Included would be those services which upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic Services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the Oregon Health Plan Prioritized List of Health Services;

(c) Services that are limited under the Oregon Medical Assistance program as identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan.

(3) In the case of non-covered condition/treatment pairs, Providers shall ensure that Oregon Health Plan Clients are informed of:

(a) Clinically appropriate treatment that may exist, whether covered or not;

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

Stat. Auth.: ORS 409

Stats. Implemented: 414.065

5-1-05

410-141-0520 Prioritized List of Health Services

Prioritized List of Health Services – Effective retroactively, for dates-of-services rendered on or after April 1, 2005 and October 1, 2005 through December 31, 2005.

(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 and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The HSC maintains the most current list on the HSC website (http://www.ohpr.state.or.us/hsc/index_hsc.htm) or, for a hardcopy, contact the Office of Health Policy and Research. This rule incorporates by reference the October 1, 2003 Prioritized List with technical revisions effective April 1, 2004, October 1, 2004, April 1, 2005 and October 1, 2005, including expanded definitions and practice guidelines, and 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) or Physician Care Organization (PCO). 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, PCO, 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.

(4) The October 1, 2003 Prioritized List with technical revisions effective April 1, 2004, October 1, 2004, April 1, 2005 and October 1, 2005, is in effect and condition/treatment pairs through line 546 are funded.

Statutory Authority: ORS Chapter 409

Statutes Implemented: ORS 414.065

10-14-05 (T)

410-141-0660 Oregon Health Plan Primary Care Manager (PCM) Provision of Health Care Services

Primary Care Managers shall ensure provision of Medically Appropriate covered services, including Preventive Services, in those categories of service included in the agreement with OMAP:

(1) Each Primary Care Manager shall provide primary care, including Preventive Services

(2) Primary Care Managers shall ensure that PCM Members have the same access to the Primary Care Manager PCM referral Practitioners that is available to non-OMAP patients.

(3) Primary Care Managers shall provide primary care to the PCM Members and arrange, coordinate, and monitor other PCM managed services for the PCM Member on an ongoing basis.

(4) Primary Care Managers shall ensure that professional and related health services provided by the Primary Care Manager or arranged through referral by the Primary Care Manager to another Provider are noted in the PCM Member's Clinical Record.

Stat. Auth.: ORS Ch. 409
Stats. Implemented: ORS 414.725

10-1-03

410-141-0680 Oregon Health Plan Primary Care Manager Emergency and Urgent Care Medical Services

Primary Care Managers shall ensure the provision of triage services for all PCM Members on a 24-hour, seven-day-a-week basis:

(1) Primary Care Managers shall ensure that appropriate Emergency Services are available to PCM Members on a 24-hour, seven-day-a-week basis.

(2) Primary Care Managers shall ensure the availability of an after-hours call-in system adequate to triage Urgent Care Services and emergency calls from PCM Members.

(3) Primary Care Managers shall have procedures for notifying a referral emergency room concerning an arriving PCM Member's presenting problem, and whether or not the Practitioner will meet the PCM Members there.

(4) During normal hours of operation, Primary Care Managers shall ensure that a health professional is available to triage Urgent Care and emergencies for Members as follows:

(a) PCM Members who walk in for service shall be assessed to determine appropriate action;

(b) PCM Members who telephone shall be assessed to determine appropriate action;

(c) Phone calls from other Providers requesting approval to treat Members shall be assessed to determine appropriate action.

(5) Primary Care Managers shall have procedures for educating PCM Members on how to access Urgent Care and emergency care. Primary Care Managers shall have methods for tracking inappropriate use of outpatient hospital emergency care and shall take action to improve appropriate use of Urgent Care and emergency care settings.

Stat. Auth.: ORS 409

Stats. Implemented: 414.725
10-1-03

410-141-0700 OHP PCM Continuity of Care

Oregon Health Plan Primary Care Manager Continuity of Care

(1) Primary Care Managers shall ensure the provision of PCM Managed Services for all PCM Members and note in the PCM Member's medical record referrals made by the Primary Care Manager to other providers for covered services:

(a) Primary Care Managers shall maintain a network of consultation and referral providers for all PCM Managed Services covered by the Primary Care Manager's agreement with OMAP. Primary Care Managers shall establish and follow procedures for referrals;

(b) Primary Care Managers shall have policies and procedures for the use of urgent care centers and emergency rooms. Primary Care Managers shall ensure that services provided in these alternative settings are documented and incorporated into the PCM Member's medical record;

(c) Primary Care Managers shall have procedures for referrals that ensure adequate notice to referral providers and adequate documentation of the referral in the PCM Member's medical record;

(d) Primary Care Managers shall personally take responsibility for, or designate a staff member who is responsible for, arrangement, coordination and monitoring of the Primary Care Manager's referral system;

(e) Primary Care Managers shall have procedures that ensure that relevant medical information is obtained from referral providers. These procedures shall include:

(A) Review of information by the Primary Care Manager;

(B) Entry of information into the PCM Member's medical record;

(C) Arrangements for periodic reports from ongoing referral appointments; and

(D) Monitoring of all referrals, where appropriate, to ensure that information is obtained from the referral providers.

(f) Primary Care Managers shall have procedures to orient and train their staff/practitioners in the appropriate use of the Primary Care Manager's referral system. Procedures and education shall ensure use of appropriate settings of care;

(g) Primary Care Managers shall have procedures for processing all referrals made by telephone, whether during or after hours of operation, as a regular referral (e.g., referral form completed, information entered into PCM Member's medical record, information requested from referral source);

(h) Primary Care Managers shall have procedures which ensure that an appropriate health professional will respond to calls from other providers requesting approval to provide care to PCM Members who have not been referred to them by the Primary Care Manager;

(i) Primary Care Managers shall enter medical information from approved emergency visits into the PCM Member's medical record;

(j) If a PCM Member is hospitalized, Primary Care Managers shall ensure that:

(A) A notation is made in the PCM Member's medical record of the reason, date, and expected duration of hospitalization;

(B) A notation is made in the PCM Member's medical record upon discharge of the actual duration of hospitalization and follow-up plans, including appointments for practitioner visits; and

(C) Pertinent reports from the hospitalization are entered in the PCM Member's medical record. Such reports shall include the reports of consulting practitioners and shall document discharge planning.

(k) Primary Care Managers shall have written policies and procedures that ensure maintenance of a record keeping system adequate to document all

aspects of the referral process and to facilitate the flow of information to the PCM Member's medical record.

(2) For PCM Members living in residential facilities or homes providing ongoing care, Primary Care Managers shall either provide the PCM Member's primary care or make provisions for the care to be delivered by the facility's "house doctor" for PCM Members who cannot be seen in the Primary Care Manager's office.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
10-1-03

410-141-0720 Oregon Health Plan Primary Care Manager Medical Record Keeping

Primary Care Manager shall ensure maintenance of a medical record keeping system adequate to fully disclose and document the medical condition of the PCM Member and the extent of covered services and/or PCM Case managed services received by PCM Members from the Primary Care Manager or the Primary Care Manager referral Provider.

(1) Primary Care Manager shall ensure maintenance of a medical record for each PCM Member that documents all types of care delivered whether during or after office hours.

(2) The medical record shall include data that forms the basis of the diagnostic impression or the PCM Member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The medical record shall also include:

(a) PCM Member's name, date of birth, sex, address, phone number;

(b) Next of kin, sponsor, or responsible party; and

(c) Medical history, including baseline data, and preventive care risk assessment.

(3) The medical record shall include, for each PCM Member encounter, as much of the following data as applicable:

(a) Date of service;

(b) Name and title of person performing the service;

(c) Pertinent findings on examination and diagnosis;

(d) Medications administered and prescribed;

(e) Referrals and results of referrals;

410-141-0740 Oregon Health Plan Primary Care Case Manager Quality Assurance System

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

(a) Primary Care Case Managers shall establish procedures and protocols for assessing quality of PCCM member care:

(A) Primary Care Case Managers shall establish procedures for response to PCCM member complaints as outlined in OAR 410-141-0780, Primary Care Case Manager Complaint Procedures;

(B) Primary Care Case Managers shall establish or adopt criteria for adequate medical care for PCCM members and shall review care received by the PCCM member against these criteria. These criteria shall include those conditions and treatments identified by the OMAP sponsored statewide quality assurance committee as in need of study, review, or improvement;

(C) Primary Care Case Managers may use the services of a local medical society, other professional societies, quality assurance organizations, or professional review organizations approved by the Secretary of the U.S. Department of Health and Human Services, to assist in reviewing criteria and protocols for the adequate medical care of PCCM members.

(b) Primary Care Case Managers are expected to maintain and improve professional competencies, when needed, in order to provide quality care to PCCM members.

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

(a) The Office of Medical Assistance Programs contracts with an external medical review organization to monitor the treatment of specific conditions

against national standards for treatment of those conditions. These tracer conditions may include, but are not limited to, asthma, anemia, diabetes, hypertension, pelvic inflammatory disease, teen pregnancy, toxemia, hypertension and diabetes in pregnancy;

(b) The Office of Medical Assistance Programs evaluates the management of adult and child preventive services through external medical review and through its research and evaluation program. These services are evaluated using national and state criteria, including criteria for mental health and chemical dependency screenings.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
2-1-94

(f) Description of treatment;

(g) Recommendations for additional treatments or consultations;

(h) Medical goods or supplies dispensed or prescribed;

(i) Tests ordered or performed and results;

(j) Health education and medical social services provided; and

(k) Hospitalization order and discharge summaries for each hospitalization.

(4) Primary Care Managers shall have written procedures that ensure maintenance of a medical record keeping system that conforms with professional medical practice, permits internal and external medical audit, permits claim review, and facilitates an adequate system for follow-up treatment. All Member medical records shall be maintained for at least four years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for record keeping within the applicable Provider type, whichever time period is longer.

(5) Primary Care Managers shall have written procedures that ensure the maintenance and confidentiality of medical record information and may release such information only to the extent permitted by the Primary Care Manager’s agreement with OMAP, by federal regulation 42 CFR 431 Subpart F and by Oregon Revised Statutes. Primary Care Managers shall ensure that confidentiality of PCM Members' medical records and other medical information is maintained as required by state law, including ORS 433.045(3) with respect to HIV test information.

(6) Primary Care Managers shall cooperate with OMAP representatives for the purposes of audits, inspection and examination of PCM Member medical records.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
10-1-03

410-141-0760 Oregon Health Plan Primary Care Managers Accessibility

(1) Primary Care Managers shall have written procedures which ensure that primary care, including Preventive Services, is accessible to PCM Members.

(2) The Primary Care Managers shall not discriminate between PCM Members and non- PCM member patients as it relates to benefits to which they are both entitled.

(3) Primary Care Managers shall have procedures for scheduling of PCM Member appointments which are appropriate to the reasons for the visit (e.g., PCM Members with non-emergency needs; PCM Members with persistent symptoms; PCM Member routine visits; new PCM Member initial assessment).

(4) Primary Care Managers are encouraged to establish a relationship with new PCM Members.

(5) Under normal circumstances, Primary Care Managers shall ensure that PCM Members are not kept waiting longer than non-PCM Member patients.

(6) Primary Care Managers shall have procedures for following up of failed appointments, including rescheduling of appointments, as deemed medically appropriate, and documentation in the PCM Member medical record of broken appointments and recall efforts.

(7) Primary Care Managers shall have procedures to ensure the provision of triage of walk-in PCM Members with urgent non-emergency medical need.

(8) When not an emergency, walk-in PCM Members should either be scheduled for an appointment as Medically Appropriate or be seen within two hours.

(9) Primary Care Managers shall have procedures that ensure the maintenance of telephone coverage (not a recording) at all times either on-site or through call sharing or an answering service, unless OMAP waives

this requirement in writing because of the Primary Care Manager's submission of an alternative plan that will provide equal or improved telephone access.

(10) Primary Care Managers shall ensure that the persons responding to telephone calls enter relevant information into the PCM Member's medical record.

(11) Primary Care Managers shall ensure a response to each telephone call within a reasonable length of time. The length of time shall be appropriate to the PCM Member's stated condition.

(12) Primary Care Managers shall have procedures that ensure that all persons answering the telephone have sufficient communication skills to reassure PCM Members and encourage them to wait for a return call in appropriate situations.

(13) Primary Care Managers are expected to have a plan to access qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking PCM Members. The plan shall address the provision of interpreter services by phone and in person. Such interpreters must be capable of communicating in English and the primary language of the PCM Members and be able to translate medical information effectively. A substantial population is 35 non-English speaking households, enrolled with the Primary Care Manager, which have the same language. A non-English speaking household is a household that does not have an adult PCM Member who is capable of communicating in English.

(14) Primary Care Managers shall provide education on the use of services, including Urgent Care Services and Emergency Services. OMAP may provide Primary Care Managers with appropriate written information on the use of services in the primary language of each substantial population of non-English speaking PCM Members enrolled with the Primary Care Manager.

(15) Primary Care Managers shall ensure that when a Medical Practitioner does not respond to a telephone call, there are written protocols specifying when a practitioner must be consulted and if Medically Appropriate, all such calls shall be forwarded to the on-call Medical Practitioner.

(16) Primary Care Managers shall have adequate practitioner backup as an operative element of the Primary Care Manager's after-hours care. Should the Primary Care Manager be unable to act as PCM for the PCM Member, the Primary Care Manager shall designate a substitute Primary Care Manager.

(17) Primary Care Managers shall ensure compliance with requirements of the Americans with Disabilities Act of 1990.

(18) Primary Care Managers shall ensure that services, facilities and personnel are prepared to meet the special needs of visually and hearing impaired PCM Members.

(19) Primary Care Managers shall arrange for services to be provided by referral providers when the Primary Care Manager does not have the capability to serve specific disabled populations.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
10-1-03

410-141-0780 Oregon Health Plan Primary Care Manager(PCM) Complaint Procedures

(1) PCMs shall have procedures for accepting, processing and responding to all Complaints from PCM Members or their Representatives:

(a) PCMs shall have procedures for resolving all Complaints. PCMs shall afford PCM Members the full use of the procedures, and shall cooperate if the PCM Member decides to pursue a remedy through the OMAP hearing process. Complaints are defined in OAR 410-141-0000, Definitions;

(b) PCMs shall designate PCM staff member or staff members who shall be responsible for receiving, processing, directing, and responding to Complaints;

(c) PCMs shall ensure that all information concerning a PCM Member's Complaint is kept confidential except that OMAP has a right to this information without a signed authorization for release of medical information from the PCM member. If a PCM Member makes a Complaint or files a hearing request, the PCM may ask the PCM Member to sign an authorization for release of medical information to those persons and to the extent necessary to resolve the Complaint or hearing request. The PCM shall inform the PCM Member that failure to sign an authorization for release of medical information may make it impossible to resolve the Complaint or hearing request;

(d) PCMs shall have procedures for informing PCM Members orally and in writing about Complaint procedures, which shall include the following:

(A) Written material describing the Complaint process; and

(B) Assurance in all written and posted material of PCM Member confidentiality in the Complaint process;

(C) Upon request, Office of Medical Assistance Programs shall provide PCMs with standard materials for tracking and documenting PCM Member Complaints.

(e) PCMs shall have procedures for the receipt, disposition and documentation of all Complaints from PCM Members PCMs shall make available copies of the Complaint forms (OMAP 3001). PCM Members may register a Complaint in the following manner. Complaints: A PCM Member may relate any incident or concern to the) PCM or other staff person by stating this is a Complaint:

(A) If the PCM Member indicates dissatisfaction, the PCM or staff person shall advise the PCM Member that he or she may make a Complaint;

(B) A staff person shall direct the PCM Member to the PCMs staff person designated for receiving Complaints;

(C) A PCM Member may choose to utilize the PCM's internal Complaint procedure in addition to or in lieu of an OMAP hearing. If a PCM Member makes a Complaint to the PCM staff person designated for receiving Complaints, the staff person shall notify the PCM Member that the PCM Member has the right to enter a written Complaint with the PCM or may attempt to resolve the Complaint orally;

(D) Complaints concerning denial of service or service coverage shall be handled as described in subsection (1)(h) of this section in addition to procedures for oral or written Complaints;

(E) All Complaints made to the PCM staff person designated to receive Complaints shall be entered into a log. The log shall identify the PCM Member, the date of the Complaint, the nature of the Complaint, the resolution and the date of resolution;

(F) If the PCM denies a service or service coverage, the) PCM shall notify the PCM Member of the right to a hearing.

(f) Oral Complaints:

(A) If the PCM Member chooses to pursue the Complaint orally through the PCM's internal Complaint procedure, the PCM shall within five working days from the date the oral Complaint was received by the PCM either:

(i) Make a decision on the Complaint; or

(ii) Notify the PCM Member in writing that a delay in the PCM's decision of up to 30 calendar days from the date the oral Complaint was received by the PCM is necessary to resolve the Complaint. The PCM shall specify the reasons the additional time is necessary.

(B) The PCM's decision shall be communicated to the PCM Member orally or in writing no later than 30 calendar days from the date of receipt of the Complaint. A written decision shall have both the Notice of Hearing Rights (OMAP 3030) and the Complaint form (OMAP 3001) attached. An oral communication shall include informing the PCM Member of their right to a hearing;

(C) If the PCM Member indicates dissatisfaction with the decision, the PCM shall notify the PCM Member that the PCM Member may pursue the Complaint further with an OMAP hearing.

(g) Written Complaints: If the PCM Member files a written Complaint with the PCM, which does not concern denial of service or service coverage, the following procedures apply:

(A) The Complaint shall be reviewed, investigated, considered or heard by the PCM;

(B) A written decision shall be made on a PCM Member's written Complaint. The decision shall be sent to the PCM Member no later than 30 calendar days from the date of receipt of the written Complaint, unless further time is needed for the receipt of information requested from or submitted by the PCM Member. If the PCM Member fails to provide the requested information within 30 calendar days of the request by the PCM, or another mutually agreed upon time-frame, the Complaint may be resolved against the PCM Member. The decision on the Complaint shall review each element of the PCM Member 's Complaint and address each of those concerns specifically;

(C) The PCM's decision shall have the Notice of Hearing Rights (OMAP 3030) attached.

(h) Complaints concerning denial of service or service coverage: If a Complaint made to the PCM staff person designated to receive Complaints

concerns a denial of service or a service coverage decision, the following procedures apply in addition to the regular Complaint procedures. The PCM staff person shall notify the PCM Member in writing of the decision which denied the service or coverage within five working days. The decision letter shall include at least the following elements:

(A) The service requested;

(B) A statement of service denial;

(C) The basis for the denial;

(D) A statement that the PCM Member has a right to request an OMAP hearing, and that in order to request such a hearing the PCM Member must submit a Fair Hearing Request Form (AFS 443) to the PCM Member's DHS office within 45 calendar days of the date of the PCM's decision on an oral or written Complaint concerning denial of service or service coverage;

(E) A statement that an OMAP hearing request may be made in addition to or instead of using the PCM's Complaint procedure;

(F) A copy of the Notice of Hearing Rights (OMAP 3030) and Fair Hearing Request (AFS 443) shall be attached.

(i) PCM Member use of PCM Complaint procedure with request for hearing:

(A) If the PCM Member chooses to use the PCM's Complaint procedure as well as the OMAP hearing process, the PCM shall ensure that either the Complaint procedure is completed prior to the date on which the OMAP hearing is scheduled or obtain the written consent of the PCM Member to postpone the OMAP hearing. If the PCM Member consents to a postponement of the OMAP hearing, the PCM shall immediately send such written consent to OMAP and to the local DHS office;

(B) The PCM staff person shall encourage the PCM Member to use the PCM's Complaint procedure first, but shall not discourage the PCM Member from requesting an OMAP hearing;

(C) If the PCM Member files a request for an OMAP hearing, OMAP shall immediately notify the PCM. The OMAP hearing process cannot be delayed without the PCM Member's consent;

(D) The PCM staff person shall begin the process of establishing the facts concerning the Complaint upon receipt of the Complaint regardless of whether the PCM Member seeks an OMAP hearing or elects the Complaint process, or both;

(E) If an OMAP hearing is requested by a PCM Member, PCM shall cooperate in the hearing process and shall make available, as determined necessary by the hearings officer, all persons with relevant information and all pertinent files and medical records.

(j) Should a PCM Member feel that his or her medical problem cannot wait for the normal PCM review process, including the PCM's final resolution, at the PCM Member's request, the PCM shall submit documentation to OMAP's medical director within, as nearly as possible, two working days for decision as to the necessity of an expedited OMAP hearing. OMAP's medical director shall decide within, as nearly as possible, two working days if that PCM Member is entitled to an expedited OMAP hearing.

(2) The PCM's documentation shall include the log of Complaints, a file of written Complaints and records or their review or investigation and resolution. Files of Complaints shall be maintained for a minimum of two calendar years from date of resolution.

(3) PCMs shall review and analyze all Complaints.

(4) PCMs shall comply with and fully implement OMAP's hearing decision. Neither implementation of an OMAP hearing decision nor a PCM Member's request for a hearing may be a basis for a request by the PCM for Disenrollment of a PCM Member.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
10-1-03

410-141-0800 Oregon Health Plan Primary Care Manager (PCM) Informational Requirements

(1) OMAP shall provide basic models of informational materials which PCMs may adapt for PCM Members' use.

(2) PCMs shall ensure that all of their staff who have contact with potential PCM Members are fully informed of the PCM and OMAP policies, including Enrollment, Disenrollment and Complaint policies.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
10-1-03

410-141-0820 Oregon Health Plan Primary Care Manager (PCM) Member Education

PCMs shall have an ongoing process of PCM Member education and information sharing which includes orientation to the PCM, health education and appropriate use of emergency facilities and Urgent Care:

(1) OMAP shall provide basic information about the use of PCM services in a PCM Member Handbook;

(2) PCMs shall provide new PCM Members with written information sufficient for the PCM Member to use the PCM's services appropriately. Written information shall contain, at a minimum, the following elements:

(a) Location and office hours of the PCM;

(b) Telephone number to call for more information;

(c) Use of the appointment system;

(d) Use of the referral system;

(e) How to access Urgent Care Services and advice;

(f) Use of Emergency Services; and

(g) Information on the Complaint process.

(3) PCMs shall have procedures and criteria for health education designed to prepare PCM Members for their participation in and reaction to specific medical procedures, and to instruct PCM Members in self-management of medical problems and in disease and accident prevention. Health education may be provided by the PCM, by any health Practitioner or by any other individual or program approved by the PCM. The PCM shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures;

(4) PCMs shall develop an educational plan for PCM Members for health promotion, disease and accident prevention, and patient self-care. OMAP may assist in developing materials that address specifically identified health education problems to the population in need.

Stat. Auth.: ORS 409
Stats. Implemented: 414.725
10-1-03

410-141-0840 Oregon Health Plan Primary Care Manager (PCM) Member Rights And Responsibilities

(1) Primary Care Managers (PCM) shall ensure that PCM Members are treated with the same privacy, dignity and respect as other patients who receive services from the Primary Care Managers.

(2) PCM Members have both rights and responsibilities as follows:

(a) PCM Members have the right to appropriate access to the Primary Care Manager. PCM Members have the responsibility to keep appointments made with the Primary Care Manager;

(b) PCM Members have the right to Preventive Services. PCM Members have the responsibility to seek periodic health exams for children and adults based on Medically Appropriate guidelines for age, sex and risk factors;

(c) PCM Members have the right to services necessary and reasonable to diagnose the presenting condition of the PCM Member. PCM Members have the responsibility to seek out diagnostic services from the Primary Care Manager except in an emergency.

(d) PCM Members have the right to appropriate Urgent Care Services; and Emergency Services. PCM Members have the responsibility to use the Primary Care Manager whenever possible. PCM Members have the responsibility to use Urgent Care Services before Emergency Services whenever possible:

(A) PCM Members have the right to written information on how to access emergency care and urgent care. PCM Members have the responsibility to use emergency care appropriately. PCM Members have the right to make a Complaint if they believe that a request for payment for Emergency Services has been erroneously denied by the Primary Care Manager. PCM Members may request a hearing before an OMAP representative if their Complaint is not acted on, to their satisfaction, by the Primary Care Manager;

(B) In addition to access to emergency care, PCM Members have the right to the following Triage services:

(i) A service which allows PCM Members to access Primary Care Managed Services and contact the Primary Care Manager on a 24-hour, 7-day-a-week basis, when the PCM Member requires urgent or emergency care;

(ii) To have the referral emergency room notified about the PCM Member's presenting problem, and whether or not the Primary Care Manager will meet the PCM Member there;

(iii) To have a health professional available to Triage urgent care and emergencies for PCM Members during regular working hours. This service includes individuals who walk in for service or who telephone for assessment.

(e) PCM Members have the right to access specialty Practitioners with the Primary Care Manager's referral when their condition warrants a referral. PCM Members have the responsibility to access specialty services through referral by the Primary Care Manager;

(f) PCM Members have the right to maintenance of a medical record which documents the medical condition of the PCM Member and the services received by the PCM Member. The PCM Member has the right of access to his or her own medical record and to request transfer of a copy of his or her own record to another Provider when appropriate. PCM Members have the responsibility to give accurate information for inclusion into the record and to request transfer of a copy of the record to a new Provider when changing Providers;

(g) PCM Members have the right to Medically Appropriate covered services which meet generally accepted standards of practice. PCM Members have the right to information about medical services which permits them to make an informed decision about proposed medical services. PCM Members have the right to refuse any recommended services. PCM Members have the responsibility to use the information to make informed decisions about services. PCM Members have the responsibility to follow prescribed treatment plans, once the PCM Member has agreed to the plan;

(h) PCM Members have the right to execute a statement of their wishes for treatment, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care. This right is established and must be adhered to in accordance with ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act.

(3) PCM Members have the right to Medically Appropriate services covered under the Oregon Health Plan. PCM Members have the responsibility to inform medical Providers of their coverage as PCM Members prior to receiving services

(4) PCM Members enrolled with Primary Care Managers or their Representatives have the right to make Complaints to Primary Care Managers and to request hearings through the OMAP hearings process. PCM Members have the responsibility to attempt resolution of Complaints with the Primary Care Manager and to sign a authorization for release of pertinent files and medical records.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
10-1-03

410-141-0860 Oregon Health Plan Primary Care Manager Provider Qualification and Enrollment

(1) Primary Care Managers shall be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

(a) Doctors of medicine;

(b) Doctors of osteopathy;

(c) Naturopathic physicians;

(d) Nurse Practitioners;

(e) Physician assistants.

(2) The following entities may enroll as Primary Care Managers:

(a) Hospital primary care clinics;

(b) Rural Health Clinics;

(c) Community and Migrant Health Clinics;

(d) Federally Qualified Health Clinics;

(e) Indian Health Service Clinics;

(f) Tribal Health Clinics.

(3) Naturopaths must have a written agreement with a physician that is sufficient to support the provision of primary care, including prescription drugs, as well as the necessary referrals for hospital care.

(4) All applicants for enrollment as Primary Care Managers must:

(a) Be enrolled as Oregon OMAP Providers;

(b) Make arrangement to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(c) Complete and sign the Primary Care Manager Application (OMAP 3119 (12/93)).

(5) If OMAP determines that the Primary Care Manager or an applicant for enrollment as a Primary Care Manager does not comply with the OHP Administrative Rules pertaining to the PCM program and/or OMAP General Rules; or if OMAP determines that the health or welfare of OMAP Members may be adversely affected or in jeopardy; OMAP may deny the application for enrollment as a Primary Care Manager; close enrollment with an existing Primary Care Manager and/or transfer the care of those PCM Members enrolled with that Primary Care Manager until such time it can be determined that the Primary Care Manager is in compliance. OMAP may also terminate the PCM Agreement without prejudice to any obligations or liabilities of either party already accrued prior to such termination. Except that the Primary Care Manager shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the Primary Care Manager's failure to terminate care for those PCM Members.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
10-1-03