

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (OHA),	Health Systems Division (Division)	410
Agency and Division		Administrative Rules Chapter Number
Sandy Cafourek	500 Summer St NE, Salem, OR 97301	(503) 945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Compliance with a January 28, 2016 CMS Informational Bulletin Requiring Alternate Benefit Changes in OHP

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

December 20, 2016	10:30 a.m.	500 Summer St. NE, Salem, OR 97301	Room 160	Sandy Cafourek
Hearing Date	Time	Location		Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-141-3070, 410-141-3300 and 410-141-3395

REPEAL:

RENUMBER:

AMEND & RENUMBER:

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

Other Auth.:

Stats. Implemented: ORS 414.610-414.685

RULE SUMMARY

The Affordable Care Act (ACA) amended section 1937 of the Social Security Act (the Act), requiring that Alternate Benefit Plan (ABP) coverage packages meet Essential Health Benefit (EHB) standards. A regulation published in 2015 made several regulatory changes to EHB standards that impact Medicaid ABPs (The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016, Final Regulation (CMS-9944-F), published by the Center for Consumer Information and Insurance Oversight (CCIIO) on February 27, 2015, (hereby called the CCIIO 2016 Payment Notice)). The Department of Labor issued interpretive information that also impacts preventive and contraceptive services under Medicaid ABPs. The CCIIO 2016 Payment Notice added new requirements for plans to use a pharmacy and therapeutics (P&T) committee starting in plan years beginning on or after January 1, 2017. Provisions regarding the P&T committee structure and operations, the formulary exceptions process, and the accessibility of formulary information were also included. Also, in order to be considered to provide EHB prescription drug coverage, health plans must publish up-to-date, accurate, and complete lists of all covered drugs on their formulary drug lists, including any tiering structures that have been adopted and any restrictions on the manner in which certain drugs can be obtained (see 45 CFR 156.122(d)). To the extent that a Medicaid ABP is furnished through a managed care network (including a pharmacy benefit manager), the ABP must satisfy the requirements of 45 CFR 156.122(e) by maintaining access to in-network retail pharmacies.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

December 22, 2016 Send written comments to: hsd.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

		
Signature	Printed name	Date

Note: Hearing Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Agency and Division	Health Systems Division (Division)	410 Administrative Rules Chapter Number
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Compliance with a January 28, 2016 CMS Informational Bulletin Requiring Alternate Benefit Changes in OHP
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-141-3070, 410-141-3300, and 410-141-3395

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

Other Authority:

Stats. Implemented: ORS 414.610-414.685

Need for the Rule(s): The need for this rule change is to provide compliance with the Alternate Benefit Plan (ABP) coverage packages to meet Essential Health Benefit standards required by the Affordable Care Act (ACA) amended section 1937 of the Social Security Act (the Act). A regulation published in 2015 made several regulatory changes to EHB standards that impact Medicaid ABPs (The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016, Final Regulation (CMS-9944-F), published by the Center for Consumer Information and Insurance Oversight (CCIIO) on February 27, 2015, (hereby called the CCIIO 2016 Payment Notice)). The Department of Labor issued interpretive information that also impacts preventive and contraceptive services under Medicaid ABPs. The CCIIO 2016 Payment Notice added new requirements for plans to use a pharmacy and therapeutics (P&T) committee starting in plan years beginning on or after January 1, 2017. Provisions regarding the P&T committee structure and operations, the formulary exceptions process, and the accessibility of formulary information were also included. Also, in order to be considered to provide EHB prescription drug coverage, health plans must publish up-to-date, accurate, and complete lists of all covered drugs on their formulary drug lists, including any tiering structures that have been adopted and any restrictions on the manner in which certain drugs can be obtained (see 45 CFR 156.122(d)). To the extent that a Medicaid ABP is furnished through a managed care network (including a pharmacy benefit manager), the ABP must satisfy the requirements of 45 CFR 156.122(e) by maintaining access to in-network retail pharmacies.

Documents Relied Upon, and where they are available: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-28-16.pdf>, CMS website and "Removing OHP Copays on All Services versus Preventive Services" policy paper, created by Jason Gingerich and Jean Hutchinson, on file with managed care policy analyst.

Fiscal and Economic Impact: See below.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Amending these rules will have minimal fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses. See attached document titled "Removing OHP Copays on All Services versus Preventive Services," page 5-Preferred Option.
2. Cost of compliance effect on small business (ORS 183.336):
 - a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The types of small businesses include doctors' offices, specialty groups, small clinics, and community based providers; however, the Division's system does not flag which providers are part of a larger clinic or corporation; therefore, the Division is unable to estimate the number of small businesses that are subject to the rules. The Division does not anticipate a direct or indirect impact on small businesses.
 - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: The Division does not anticipate additional administrative activities required for compliance or costs of professional services.
 - c. Equipment, supplies, labor and increased administration required for compliance: The Division does not anticipate additional administrative activities required for compliance or costs of professional services.

How were small businesses involved in the development of this rule? The rules are federally mandated.

Administrative Rule Advisory Committee consulted?: Yes-9/29/16.

Signature  Printed name Karen Wheeler Date 10/25/16

410-141-3070

Preferred Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. CCOs shall pay for prescription drugs except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants), (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (814) and (915) of this rule;

~~(c) Any applicable co-payments;~~

~~(d) For drugs covered under Medicare Part D when the client is fully dual eligible.~~

(2) CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.

(3) CCOs 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 (PA).
~~The drug list shall:~~

(4) CCOs shall publish up-to-date, accurate, and complete lists of all covered drugs on their preferred drug lists, including any tiering structures, that have been adopted and any restrictions on the manner in which certain drugs can be obtained.

(5) As specified in 45 CFR 156.122, the preferred drug list must:

(a) Exist in a manner easily accessible to members and potential members, state and federal government, and the general public;

(b) Be accessible on the plan's public website through a clearly identifiable web link or tab without requiring an individual access account or policy number; and

(c) If the issuer has more than one plan, the member should be easily able to discern which of the preferred drug lists applies to which plan.

(6) The preferred drug list shall:

(a) Include Federal Drug Administration (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.

(7) CCOs shall cover at least one form of contraception within each of the eighteen methods identified by the FDA. As stated in 410-141-3320, the member may refer oneself directly to family planning services without getting a referral from a PCP or other participating provider;

~~(38)~~ CCOs 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 made to their drug list within 30 days of a change that may include, but are not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(49) Preauthorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent preauthorization for a prescription drug cannot be completed within 24 hours, the CCO shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All requests, including those not marked urgent, shall be reviewed and decision rendered within 72 hours of original receipt of the preauthorization request.

~~(510)~~ CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the approved prescriber certifies medical necessity for the drug such as:

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

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

~~(611)~~ Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.

~~(712)~~ CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of

Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List.

(813) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:

(a) The drug name;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Authority should consider this drug for carve out.

(914) If a CCO requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.

(1015) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). A CCO may not reimburse providers for carved-out drugs.

(1416) CCOs shall submit quarterly utilization data within 60 days of the date of service as part of the CMS Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

(1217) CCOs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

(18) CCOs shall utilize a pharmacy and therapeutics (P&T) committee to maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR 156.122 (3) (i) and (ii). Meetings shall be held at least quarterly.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610–414.685

410-141-3300

Coordinated Care Organization (CCO) Member Education and Information Requirements

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

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state's top sixteen preferred written languages as identified by OHP enrollees. CCOs shall insert their contact information into the template.

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(d) "Prevalent Non-English Language" means: All non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1, 000 of the CCO's members.

(2) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(3) CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

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

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that interpreter services at provider offices are free to CCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and

information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.

(10) Provider directories shall include notation of the following: names including names of in-network retail and mail-order pharmacies, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients.

(11) For those who are existing members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request.

(12) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes.

(b) Alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit.

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services.

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large type, and braille.

(13) A CCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille.

(c) CCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs and the CCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of intensive care coordination services and how members with the following special health care needs can access intensive care coordination services: Those who are aged, blind, or disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency.

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

- (L) Information on contracted hospitals in the member's service area;
- (m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;
- (n) Information on the CCO's grievance and appeals processes and the Division's contested case hearing procedures, including:
 - (A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3260;
 - (B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263.
- (o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;
- (p) Information on ~~copayments~~, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care, including information specific to ~~copayments~~, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;
- (q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;
- (r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;
- (s) Information on advance directive policies including:
 - (A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
 - (B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.
- (t) Whether or not the CCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How to access in-network retail and mail-order pharmacies;

(zy) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(aaz) The CCO's confidentiality policy;

(aabb) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(bbcc) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;

(eedd) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(ddee) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(14) Member health education shall include:

(a) 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. CCO providers or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) Information specifying that CCOs may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(A) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the enrollee needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(d) Explanation of intensive care coordination services and how to access intensive care coordination through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) CCOs shall provide free interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care:

(A) CCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(B) CCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language.

(b) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

(16) CCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

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

Stats. Implemented: ORS 414.610 - 414.685

410-141-3395

Member Protection Provisions

(1) In the event of a finding of impairment by OHA or of a termination of certification as a CCO or of the CCO contract, members of the CCO shall be offered disenrollment from the CCO and enrollment in accordance with OHA rule.

(2) For the purpose of this section only, and only in the event of a finding of impairment by OHA or of a termination of certification or of the CCO contract, any covered health care service furnished within the state by a provider to a member of a CCO shall be considered to have been furnished pursuant to a contract between the provider and the CCO with whom the member was enrolled when the services were furnished.

(3) Each contract between a CCO and a provider of health services shall provide that if the CCO fails to pay for covered health services as set forth in the contract, the member is not liable to the provider for any amounts owed by the CCO.

(4) If the contract between the contracting provider and the CCO has not been reduced to writing or fails to contain the provisions required by this rule, the member is not liable to the contracting provider for any amounts owed by the CCO.

(5) No contracting provider or agent, trustee or assignee of the contracting provider shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule and under 410-120-1280.

(6) Nothing in this section impairs the right of a provider to charge, collect from, and attempt to collect from or maintain a civil action against a member for any of the following:

(a) Deductible, ~~copayment~~ or coinsurance amounts;

(b) Health services not covered by the CCO, if a valid ~~DMAP OHP~~ 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

(c) Health services rendered after the termination of the contract between the CCO and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract. Before providing a non-covered service, the provider must complete ~~aan~~ DMAP OHP 3165, or facsimile, as described in OAR 410-120-1280.

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

Stats. Implemented: ORS 414.610 - 414.685