~~Table of~~ Contents

410-141-3500 Definitions

(1) The following definitions apply with respect to OAR chapter 410, division 141. The Authority also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.

(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision.

(3) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.

(4) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.

(5) "The Authority" means the Oregon Health Authority.

(6) "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; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.

(7) "Auxiliary Aids and Services" means services available to members as defined in 45 CFR Part 92.

(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.

(11) "Capitated Services" means those covered services that an MCE agrees to provide for a capitation payment under contract with the Authority.

(12) "Capitation Payment" means monthly prepayment to an MCE for capitated services to MCE members.

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

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

(15) “Client” means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE member.

(16) “Community Advisory Council (CAC)” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625. CCOs shall afford an opportunity for tribal participation on CACs as follows:

~~(17~~

(a) In CCO service areas where only one federally recognized tribe exists, the tribe shall appoint one tribal representative to serve on the CAC;

(b) In CCO service areas where multiple federally recognized tribes exist, each tribe shall appoint a tribal representative to serve on the CAC to ensure full representation of all tribes within the service area;

(c) In metropolitan CCO service areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.

(17) “Community Benefit Initiatives” (CBI) means community-level interventions focused on improving population health and health care quality.

(18) “Contract” means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.

(~~18~~19) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

(~~19~~20) “Coordinated Care Services” mean an MCE’s fully integrated physical health, behavioral health services, and oral health services.

(~~20~~21) “Corrective Action” or “Corrective Action Plan” means an Authority-initiated request for an MCE or an MCE-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(~~21~~22) "Dental Care Organization (DCO)" means an MCE that provides and coordinates ~~dental~~oral health services as capitated services under OHP.

(~~22~~23) "The Department" means the Department of Human Services.

(~~23~~24) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.

(~~24~~25) "Disenrollment" means the act of removing a member from enrollment with an MCE ~~or~~.

(26) "Diversity of the ~~Oregon Health Plan~~Workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.

(~~25~~27) "Enrollment" means the assignment of a member to an MCE for management and ~~receipt~~coordination of health services.

(~~26~~28) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Prescription contraceptives (such as birth control pills, patches or rings);

(d) IUDs and implantable contraceptives and the procedures requires to insert and remove them;

(e) Injectable hormonal contraceptives (such as Depo-Provera);

(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);

(g) Laboratory tests including appropriate infectious disease and cancer screening;

(h) Radiology services;

(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.

(29) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits.

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

(~~27~~31) "Grievance System" means the overall system that includes:

(a) Grievances to an MCE on matters other than adverse benefit determinations;

(b) Appeals to an MCE on adverse benefit determinations; and

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

(~~28~~32) "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.

(~~29~~33) "Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.

(~~30~~34) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP.

(~~31~~35) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, ~~especially one considered outside~~such as the ~~mainstream~~practices of ~~scientific medicine as~~ naturopathy or chiropractic and often involving nutritional measures.

(~~32~~36) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency.

(37) "Indian" means an American Indian or Alaska Native, and refers to any individual who:

(a) Satisfies the criteria defined at 25 USC §§ 1603(13), 1603(28), or 1679(a);

(b) Has been determined eligible as an Indian, under 42 CFR § 136.12;

(c) Is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services.

(~~33~~38) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

(~~34~~39) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

(40) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(~~35~~41) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.

(~~36~~42) "Legal Holiday" means the days described in ORS 187.010 and 187.020.

(~~37~~43) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(~~38~~44) "Managed Care Entity (MCE)" means, as stated in 42 CFR 457.10, an entity that enters into a contract with the Authority to provide services in a managed care delivery system including but not limited to coordinated care organizations, dental care organizations, mental health organizations, and primary care case managers.

(~~39~~45) "Medicaid-Funded Long-Term Care, Services, and Supports (LTCSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:

(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals~~.~~;

(b) “Long-term Services and Supports,”the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.

(~~40~~46) “Member”means an OHP client enrolled with an MCE.

(~~41~~47) “Member Representative”means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.

(~~42~~48) “Mental Health Organization (MHO)”means an MCE that provides capitated behavioral services for clients.

(~~43~~49) “National Association of Insurance Commissioners (NAIC)”means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

~~(44) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments.~~

(~~45~~50) “Non-Participating Provider”means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.

(~~46~~51) “Ombudsperson Services”means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.

(~~47~~52) “Oral Health”means conditions of the mouth, teeth, and gums, the diagnosis and treatment for which falls within the scope of practice.

(53) “Oregon Health Plan (OHP)”means Oregon’s Medicaid program ~~together with~~or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon’s Medicaid program or a related state-funded health program, or both.

(~~48~~54) “Oregon Integrated and Coordinated Health Care Delivery System”means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.620.

(~~49~~55) “Participating Provider”means a provider that has a contractual relationship with an MCE and is on their panel of providers.

(~~50~~56) "Participating Provider Organization" means a group practice, facility, or organization that has a contractual relationship with an MCE and is on the MCE's panel and;

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim;

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization; and

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider.

(57) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.

(58) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.

(~~51~~59) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients~~, as defined in OAR 410-120-0000~~. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:

~~(52) (57~~

(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;

(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000.

(60) "Provider" means, pursuant to OAR 410-120-0000, an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering

provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.

(61) "Provider Organization" means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim;

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization; and

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider.

(62) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(~~53~~63) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.

(~~54~~64) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:

(a) A child or youth, between the ages of birth to 21 years of age; and

(b) Must meet criteria for diagnosis, functional impairment and duration:

(A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):

(i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);

(ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).

(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;

(C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year.

(65) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.

(66) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.

(67) "Trauma-informed services" means those services provided using a Trauma Informed Approach.

(68) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.

(69) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.

(70) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It

means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3501 Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence

(1) The Authority ~~and it's~~ may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Oregon Integrated and Coordinated Health Care Delivery System and medical assistance programs. This includes the Oregon Health Plan (OHP) pursuant to ORS Chapter 414, subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) To the extent possible, the Authority's policies, procedures, rules, and MCE contracts shall be interpreted to avoid a conflict among themselves or with governing state or federal law. In the event of an irreconcilable conflict, the following order of precedence shall govern:

~~(a) Federal statutes and regulations;~~

~~(b) Waivers granted the Authority by~~

(a) Medicaid Plan and waivers or other directives from CMS;

(~~c~~b) Federal Statutes;

(c) Federal Regulations;

(d) Oregon Revised Statutes;

(~~d~~e) Oregon Administrative Rules~~,~~ using the following order of precedence:

(A) This OAR chapter 410 division 141 ("Oregon Health Plan");

(B) OAR chapter 410 division 120 ("Medical Assistance Programs");

(C) Any applicable ~~provider~~Provider rules in OAR 410 based on the category of health service;

(D) OAR ~~chapter~~Chapter 943 ~~division~~, Division 120 ;

(~~"Provider Rules")~~E) OAR Chapter 309;

~~(e~~

(F) All other applicable OARs;

(f) The MCE Contract, ~~(~~including any internal order of precedence established therein~~)~~.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3505 Use of Subcontractors ~~(Revised 8/2/19)~~

~~(1) MCEs may delegate their activities or obligations to subcontractors except as otherwise provided by law or in the MCE contract.~~

(1) MCEs may delegate their activities or obligations to subcontractors except as otherwise provided by law or in the MCE contract:

(a) MCEs remain fully accountable for the performance of all subcontracted work~~.~~;

(b) MCEs shall notify the Authority of subcontractor relationships. MCEs shall provide the Authority:

(A) A comprehensive list of subcontractor entities and, for each one, the activities and functions that have been delegated, to be submitted to OHA on an annual basis;

(B) Copies of all subcontracts upon request; and

(C) Adequate documentation demonstrating monitoring of subcontractor compliance or subcontractor auditing, as applicable, in accordance with the contract and with CMS requirements including 42 C.F.R §§ 438.230, 438.602(a) and 438.66.

(2) Each subcontract must include the following elements:

(~~A~~a) With respect to any MCE activities or obligations defined by law or in the MCE's contract with the ~~state~~Authority that the MCE is delegating to a subcontractor:

(~~i~~A) The subcontract must specify the delegated activities or obligations, as well as any related reporting responsibilities;

(~~ii~~B) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations; and

(~~iii~~C) The subcontract must either provide for revocation of the delegation or specify other remedies in instances where the ~~state~~Authority or the MCE determines that the subcontractor has not performed satisfactorily.

(~~B~~b) The subcontractor agrees to comply with all applicable laws, regulations, sub-regulatory guidance, as well as the requirements in the MCE contract:

(A) The subcontractors agree to comply with Section C Part 10 of Attachment I of the 2017-2022 Medicaid 1115 Waiver regarding timely Payment to IHCP Providers.

(B) Timely payments means that IHCPs must be paid the agreed upon rate within 30-90 calendar days of billing.

(C) The subcontractor agrees to perform any activities necessary to support the MCE and the ~~state~~Authority's obligations as specified in the MCE contract, state law, and federal law, including requirements related to:
(i) Program integrity and data submission, including the requirements in 42 CFR, Part 438, Subpart H.;

(ii) Grievances and appeals, including the requirements in 42 CFR, Part 438, Subpart F;

(iii) Exclusions, as noted in 42 CFR § 438.808; and

(iv) Linguistic and disability access for members, as outlined in 42 CFR § 438.10, as well as 42 U.S.C. § 18116 and 45 CFR Part 92.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3510 Provider Contracting and Credentialing

(1) ~~CCOs~~MCEs shall ~~select providers using universal application~~develop policies and procedures for credentialing ~~procedures and objective~~providers to include quality ~~information. CCOs shall take steps~~standards and a process to remove providers from their provider network if they fail to meet the objective quality standards~~.~~:

(a) ~~CCOs~~MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the ~~CCO~~MCE and re-credentialed no less frequently than every three years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. ~~CCOs~~MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application~~.~~:

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

(c) ~~CCOs~~MCEs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, ~~CCOs~~MCEs shall:

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

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

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

(A) License or certification expiration and renewal dates;

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

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

(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.

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

(A) Have been terminated from ~~OHP~~Medicaid;

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

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

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

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

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

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

(2) ~~A CCO~~An MCE may not discriminate with respect to participation in the ~~CCO~~MCE against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If ~~a CCO~~an MCE declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:

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

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

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

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

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

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

(4) To resolve appeals made to the Authority under sections (~~4~~3) and (~~5~~4) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the ~~CCO~~MCE to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the ~~CCO~~MCE's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(5) A prevailing party in an appeal under sections (~~4~~3) through (~~6~~4) of this rule shall be awarded the costs of the appeal.

(6) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.

(7) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

(8) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3515 ~~Accessibility~~Network Adequacy

~~(1)~~ (1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services ~~for~~to both current members and those the MCE anticipate will become enrolled as members.

~~(2)~~ (2) The MCE shall develop a provider network that enables members to access services within the standards defined below.

~~(3)~~ (3) The MCE shall meet access-to-care standards and that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

(4) MCEs shall meet quantitative network access standards ~~specified~~defined in rule and ~~published by the Authority~~contract.

(5) ~~MCEs~~CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(6) In developing its provider network, the ~~MCE~~CCO shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health ~~issues~~conditions, in the most appropriate and independent setting, including in their own home or independent supported living.

(7) ~~MCEs~~CCOs shall ensure all members can access providers within acceptable travel time or distance to patient-centered primary care homes or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral care, adult and pediatric; and additional provider types when it promotes the objectives of the Authority. Acceptable travel times and distances may not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas, 30 miles, or 30 minutes;

(b) In rural areas, 60 miles, or 60 minutes.

(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan shall include how the CCO will meet the accommodation and language needs of individuals with LEP as defined in 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including

but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act ~~and~~, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973.

(9) ~~MCEs~~CCOs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers ~~sufficiently~~ qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.

(10) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health ~~issues~~conditions, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. Specifically, MCEs shall monitor and have policies and procedures to ensure~~;~~:

(a) ~~(a)~~ Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services~~.~~;

~~(b)~~ (b) Priority access for pregnant women and children ages birth through 5 years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.

(11) ~~MCEs~~CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:

~~(a)~~ (a) Physical health:

~~(A)~~ (A) Emergency care: Immediately or referred to an emergency department depending on the member's condition~~.~~;

~~(B)~~ (B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840~~.~~;

(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.

~~(b)~~ (b) Oral care:

(A) ~~(A)~~ Emergency oral care: Seen or treated within 24 hours;

~~(B)~~ (B) Urgent oral care: Within one week or as indicated in the initial screening in accordance with OAR 410-123-1060~~.~~;
(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than ~~8~~eight weeks appropriate.

(c) Behavioral health:

(A) Urgent behavioral health care for all populations: Immediately~~.~~;

(B) Specialty behavioral health care for priority populations :

(i) In accordance with the timeframes listed below for assessment and entry, terms are defined in OAR 309-019-1015, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135~~.~~;

(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist~~.~~;

(iii) IV drug users: Immediate assessment and entry. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist~~.~~;

(iv) Opioid use disorder: Assessment and entry within 72 hours~~.~~;

(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry~~.~~;

(vi) Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.

(C) Routine behavioral health care for non-priority populations: assessment within seven days of the request, with a second appointment occurring ~~no more than 14 days later, and 4 appointments (including the second appointment) within 48 days~~as clinically appropriate.

(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who ~~are~~have limited English proficiency, living in a household where there is no adult available to communicate in English or there is no telephone~~.~~:

(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives ;

(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members. ;

(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member. ;

(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCES shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;

(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary. ;

(f) MCEs shall have a plan for ensuringcollect and actively monitor data on language accessibility to ensure compliance with these language access requirements and shall monitor for compliance. ;

(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:

(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;

(B) MCEs shall complete a quarterly language access and interpreter services data report using the report form provided by the Authority. The quarterly language access and interpreter services

data report shall be submitted to the Authority on or before the third Monday of each January, April, July, and October;

(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.

(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), hours of operation, and call center performance and accessibility.

(14) MCEs must report annually to the Authority such access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports~~, an annual analysis of behavioral~~ on:

(a) Behavioral health access~~, and an annual analysis of~~;

(b) Interpreter utilization by the MCE's ~~contracted behavioral~~provider network;

(c) Behavioral health ~~workforce~~provider network.

(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).

(16) MCEs shall implement and require its providers to adhere to the following appointment and wait time standards:

(a) Wait times for scheduled appointments shall not exceed 60 minutes. After 30 minutes, members must be given an update on waiting time with an option of waiting or rescheduling the appointment~~.~~;

(b) MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:

~~(i) Determining why appointments are not kept;~~

~~(ii)~~ (A) Timely rescheduling of missed appointments, as deemed medically appropriate;

~~(iii)~~ (B) Documentation in the clinical record or non-clinical record of missed appointments;

~~(iv)~~ (C) Recall or notification efforts; and

~~(v) Outreach services.~~

(D) Method of member follow up.

~~(c)~~ (c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, MCEs shall provide outreach services as medically appropriate~~.~~;
(d) Recognition of whether NEMT services were the cause of the member's missed appointment.

(17) ~~MCEs~~CCOs must contract with the following specific provider types:

(a) Providers of residential chemical dependency treatment services ~~and notify the Authority within 30 days of executing new contracts.~~;

(b) Any ~~dental~~oral care organizations necessary to provide adequate access to oral services in the area where members reside.

(18) ~~MCEs~~CCOs shall assess the needs of their membership and make available supported employment and assertive community treatment services when members are referred and eligible~~.~~;

~~(a) MCEs~~(a) CCOs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by OHA. When no appropriate provider is available, the MCE shall consult with the Authority and develop an approved plan to make supported employment and assertive community treatment services available~~.~~;

~~(b)~~ (b) If ~~ten~~10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive assertive community treatment for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:

~~(i)~~ (A) Increasing team capacity to a size that is still consistent with fidelity standards; or

~~(ii)~~ (B) Adding additional Assertive Community Treatment teams; or

(~~iii~~C) When no appropriate Assertive Community Treatment provider is available, the ~~MCE~~CCO shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.

Statutory/Other Authority: ORS ~~413.032~~413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3520 Record Keeping and Use of Health Information Technology

(1) MCEs 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., the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. MCEs shall communicate these policies and procedures to subcontractors. MCEs shall regularly monitor its subcontractors' compliance and take any corrective action necessary. MCEs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules. A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices.

(2) MCE's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member requests copies of their records.

(3) Notwithstanding ORS 179.505, an MCE, its provider network, and programs administered by the Department's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services, and reimbursement in order to improve the safety and quality of care, lower the cost of care, and improve the health and well-being of the members.

(4) An MCE and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and behavioral health diagnoses within the MCE for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Re-disclosure of individually identifiable information outside of the MCE and the MCE's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 and 414.655 remains subject to any applicable federal or state privacy requirements including the Authority's rules established in OAR 943-014-0000 through 0070 for matters that involve privacy and confidentiality and privacy of members protected information.

(5) The MCE must document its methods and findings to ensure across the organization and the network of providers there is documentation of the coordinated care services and supports, including transitions of care and access to preventive and wellness services.

(6) MCEs shall support the adoption and use of electronic health records (EHRs) by its provider network, including physical, behavioral, and oral health providers. To achieve EHR adoption, MCEs shall:

(a) Identify EHR adoption rates, divided by provider type (at a minimum, divided by physical, behavioral, and oral health) and geographic region if applicable;

(b) Develop and implement strategies to increase adoption rates of EHRs among all provider types; and

(c) Support EHR adoption.

(7) MCEs shall support access to electronic health information exchange (HIE) for care coordination and hospital event notifications for contracted physical, behavioral, and oral health providers. To achieve improved HIE access rates, MCEs shall:

(a) Identify current and monitor ongoing ~~HI~~HIE adoption rates, divided by provider type (at a minimum, divided by physical, behavioral, and oral health) and geographic region if applicable;

(b) Develop and implement strategies to increase access to HIE among all provider types;

(c) Support access to HIE; and

(d) Ensure that providers have access to hospital event notifications. The MCE shall itself use hospital event notifications as appropriate to support care coordination and population health efforts.

(8) MCEs shall maintain health information systems that collect, analyze, integrate, and report data at an individualized member level concerning the provision of covered services and CCO administrative functions, such as enrolment/disenrollment and resolution of grievances and appeals. Based on written policies and procedures, the record keeping system developed and maintained by MCEs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member.

(9) MCEs and their provider network shall cooperate with the Authority, the Department of Justice Medicaid Fraud Control Unit (MFCU), and CMS or other authorized state or federal reviewers for purposes of audits, inspection, and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services are authorized and provided, referrals are made, and outcomes of coordinated care and referrals are sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.

(10) Across the MCE's provider network, all clinical records shall be retained for a minimum of ~~ten~~10 years after the date of services for which claims are made. MCEs shall maintain any other records, books, documents, papers, plans, records of shipments, and payments and writings, whether in paper, electronic, or other form that are pertinent in a manner that clearly documents the MCE's performance. All clinical records, financial records, other records, books, documents, papers, plans, records of shipments, and payments and writings of the MCE whether in paper, electronic, or other form are collectively referred to as "Records." If an audit, litigation, research

and evaluation, or other action involving the records is started before the end of the ten-year period, the clinical records must be retained until all issues arising out of the action are resolved.
(11) MCEs shall allow access to the agencies listed in section (9) of all audit records and its subcontractors and participating provider's records to allow the listed agencies to perform examinations and audits and make excerpts and transcripts and to evaluate the quality, appropriateness, and timeliness of services.

(12) MCEs shall allow access to the entities listed in section (9) at any time to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. MCEs subject to an audit under this section shall retain records for ~~ten~~10 years from the final date of the contract period or from the date of completion of the most recent state audit, whichever is later. MCEs shall retain and keep accessible all records for a minimum of ~~ten~~10 years. County agencies participating in the Medicaid program are subject to whichever record retention requirement is longer between this rule and OAR chapter 166, division 150 County and Special District Retention Schedule.

(13) MCEs must maintain yearly logs of all appeals and grievances for ~~ten~~10 years following requirements specified in OAR 410-141-3915.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3525 Outcome and Quality Measures

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

(2) The MCE shall inform the Authority if it has been accredited by a private independent accrediting entity. If the MCE has been so accredited, the MCE shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review ~~in accordance with CFR 42 §438.332~~.

(3) As required by health system transformation, MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. Measures are selected by OHA; with ~~specifically~~ the incentive measures ~~are~~specifically adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at the Metrics and Scoring Committee website located at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx.

(4) MCEs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health care, oral health care, and all other health services provided by or under the responsibility of the MCE as specified in the MCE's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.

(5) MCEs shall ~~implement~~maintain an ~~ongoing comprehensive quality assessment and performance improvement program, QAPI~~effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the ~~MCEMCE~~MCE's contract. This process shall include an internal Quality Improvement (QI) program with written criteria based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with ~~requirements set for in CFR 42 §438.330,~~ relevant law and the community standards for care, ~~and/~~or = in accordance with accepted medical practice, whichever is applicable, and with accepted professional standards. MCEs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with MCE contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3890 through 410-141-3915;

(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid funded long-term care or long-term services and supports benefits; or who are children receiving CAF (Child Welfare) or OYA services; and

(e) Report on the diversity and capacity of the workforce in their service area including capacity to provide services in a culturally responsive and trauma informed manner, relying, as appropriate, on workforce data provided by the Authority.;

(f) Undertake performance improvementQI projects that are designed to improve the access, quality and utilization of services. Projects must be designed to achieve significant improvement in health outcomes and enrollee satisfaction.

(6) MCEs shall implement policies and procedures that assure it collectsthe collection of timely data including health disparities and other data required by rule or contract (or both) that allows the MCE to conduct and report on its outcome and quality measures and report its performance. MCEs shall submit to the Authority the MCE's annual written evaluation of outcome and quality measures established for the MCE or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee; including but not limited to output from Electronic Health Records, Chart Reviews, Claim validation reports and other materials required for final assessment of relevant measures and within established deadlines.

(7) MCEs shall adopt practice guidelines consistent with 42 CFR § 438.236 and the MCE contract that addresses assigned contractual responsibilities for physical health care, behavioral health care, or oral health care; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3860; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.

(8) MCEs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts. Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) eCQMs or HEDIS that have state or national normative statistics.;

(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational

measures may include culturally informed care, health equity or health-related services not typically associated with medical care. Transformational metrics will also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.

(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the MCE agreement in the manner authorized by OAR 409-025-0130.

(10) 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. MCEs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The ~~Quality Improvement~~QI 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 Authority members including those who are eligible for intensive care coordination (ICC) services under OAR 410-141-3870 or shall be able to retain consultation from individuals who are qualified.

(11) MCEs 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. These records and minutes shall be made available to relevant OHA quality staff;

(b) ~~MCEs shall conduct~~Conduct and submit to the Authority an annual written evaluation of the ~~QAPI~~QI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the ~~QAPI~~QI program and member care is to include ~~an assessment of annual activities conducted which includes a background and rationale for activities implemented; a plan of~~a description of completed and ongoing ~~improvement~~QI activities ~~to address gaps, which will ensure quality of care for MCE's members; and~~, member education and an evaluation of the overall effectiveness of the QI program. ~~MCEs shall submit the~~This evaluation ~~to the Authority and, upon request by the Authority, the Authority's contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy requirements as outlined in MCE contract for the QAPI and transformational care annual evaluation criteria.~~ shall include:

(A) Prevention programs;

(B) Care of members who are in the ICC program;

(C) Disease management programs;

(D) Adverse outcomes of members, with particular attention to members in the ICC program;

(E) Actions taken by the MCE to address health care concerns identified by 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-network utilization; medication review; MCE-initiated disenrollment's; 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 member complaints and appeals as required in OAR 410–141-3915;

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

(12) MCEs that are NCQA accredited or accredited by other Authority-recognized accreditation organizations shall be deemed to have satisfied section (11)(b) of this rule. MCEs deemed by the Authority shall annually submit to the Authority an evaluation of the ICC program. Copies of accreditation reports shall be submitted to the Authority within 60 days of issuance.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3530 Sanctions

(1) The Authority may establish and impose sanctions on MCEs, pursuant to 42 CFR § 438.700, if the Authority makes a determination specified in paragraph (3) of this rule.

(2) The Authority may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(3) The Authority may impose sanctions if the Authority determines that an MCE acts or fails to act as follows:

(a) Fails substantially to provide medically necessary services required under law or under its contract with the Authority to an enrollee covered under the contract;

(b) Imposes on enrollee's premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

(d) Misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services (CMS) or to the ~~state~~Authority;

(e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;

(f) Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210;

(g) Distributes directly or indirectly through any agent or independent contractor marketing materials that are not approved by the Authority or that contain false or materially misleading information;

(h) Violates any of the other applicable requirements of state or federal Medicaid law; or

(i) Fails to comply with any legal or contractual requirements that, pursuant to the MCE contract, may form a basis for sanctions.

(4) The Authority may impose a range of sanctions under this rule including the following:

(a) Civil monetary penalties in the amounts specified in section (5) of this rule;

(b) Appointment of temporary management for an MCE as permitted under 42 CFR 438.706;

(c) Granting ~~member's,~~members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

(d) Suspension of all new enrollment, including default enrollment, after the date the Authority notifies the MCE of a determination of a violation of rule or contract requirements;

(e) Suspension of payment for members enrolled after the effective date of the sanction and until the Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

(f) Additional sanctions available under Oregon Revised Statutes and Oregon Administrative Rules that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance.

(5) If the Authority imposes civil monetary penalties:

(a) The maximum civil monetary penalty the Authority may impose varies depending on the nature of the MCE's action or failure to act, subject to the limits in 42 CFR § 438.704;

(b) The Authority may issue penalties as specified on a per event, per member impacted, or per day basis for the duration of noncompliance.

(6) Before imposing any sanctions, the Authority must give the affected MCE timely written notice that explains the following:

(a) The basis and nature of the sanction;

(b) Any appeal rights under this rule and any other appeal rights that the Authority elects to provide.

(7) Administrative review, and if requested mediation:

(a) Are available for review of sanction decisions in accordance with OAR 410-120-1580 and 410-141-3550;

(b) If the Authority determines that there is continued egregious behavior, or that such action is necessary to ensure the health or safety of members, the Authority may impose the sanction before an administrative review opportunity is provided.

(8) Before terminating an MCE's contract for cause, the Authority must provide the MCE the opportunity for a pre-termination hearing. The Authority must do all of the following:

(a) Give the MCE written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

(b) After the hearing, give the MCE written notice of the decision affirming or reversing the proposed termination of the contract and for an affirming decision the effective date of termination;

(c) For an affirming decision, give enrollees of the MCE notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3540 Member Protections

(1) In the event of a finding of ~~CCO~~MCE impairment by the Authority, or of a termination of ~~certification as a CCO or of~~ the ~~CCO~~MCE contract, members of the ~~CCO~~MCE shall be offered disenrollment from the ~~CCO~~MCE and enrollment in accordance with the Authority's rules.

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

(3) Each contract between ~~a CCO~~an MCE and a provider of health services shall provide that if the ~~CCO~~MCE 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~~MCE.

(4) If the contract between the contracting provider and the ~~CCO~~MCE 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~~MCE.

(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~~MCE 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 or coinsurance amounts;~~

~~(b~~

(a) Health services not covered by the ~~CCO~~MCE, if a valid OHP Client Agreement to Pay for Health Services form OHP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

(~~c~~b) Health services rendered after the termination of the contract between the ~~CCO~~MCE 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 an OHP 3165, or facsimile, as described in OAR 410-120-1280.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3545 Coordinated Care Organization ~~Substance Use Disorder~~Behavioral Health Provider, Treatment and Facility Certification and Licensure

(1) ~~Certain Behavioral Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP), or authorized Coordinated Care Organization (CCO).~~

~~(2) Substance Use Disorder (SUD)~~Behavioral health treatment services are covered for eligible OHP clients when provided by a CCO under the following circumstances~~.~~:

(a) ~~The provision of SUD services shall comply~~Provider Organizations (as defined under OAR 410-120-0000) of outpatient behavioral health services shall:

(A) Be certified by the Authority as described in OAR 309-008-0250 for the scope of services provided; and

(B) Comply with applicable rules, including but not limited to, those defined in OAR chapter ~~415, divisions 12, 20, and 50; OAR chapter 309, divisions 18, 19, and 22;~~309 and any requirements in the CCO contract.

~~(b) Outpatient substance use disorder providers that are facilities or agencies shall have a certificate issued by the Authority as described in OAR 415-012-0000 for the scope of services provided.~~

(b) A certificate may not be required for certain types of providers, regardless of whether public funds are received, as outlined in OAR 309-008-0250(4);

(c) Provider organizations (as defined under OAR 410-120-0000) of residential treatment services shall:

(~~c~~A) ~~Any facility that meets~~Meet the definition of a residential treatment facility ~~for substance-dependent persons~~ under ORS 430.010, 430.306 and 443.400~~, or of a detoxification center as defined in ORS 430.306, shall be~~;

(B) Be licensed by the Authority as described in ORS 443.725 and OAR chapter 415~~-012-0000~~ divisions 12 and 50 for the scope of service provided~~.~~; and

~~(d) Detoxification centers shall have a license issued by the Authority as described in OAR 415-012-0000 and 415-050-0000 for the scope provided.~~

(C) Comply with applicable rules including, but not limited to, those defined in OAR chapter 415 and chapter 309 and any requirements in the CCO contract.

Statutory/Other Authority: ORS ~~192.527, 192.528,~~ 413.042 ~~&~~, 414.065, 430.010, 430.306, 443.400 & 443.725
Statutes/Other Implemented: ORS ~~192.527, 192.528,~~ 413.042, ~~414010,~~ 414.065, 414.010, 430.306 & ~~414.727~~443.400

410-141-3550 Resolving Disputes between ~~CCOs~~MCEs and the Authority

(1) If ~~a CCO~~an MCE has a dispute with the Authority as a result of a decision that is perceived as adversely affecting ~~a CCO~~an MCE, the ~~CCO~~MCE may submit a request to the Director of the Authority, or the Director's designee, requesting an Administrative Review, as prescribed in OAR 410-120-1580.

(a) These disputes primarily address legal or policy issues that may arise in the context of an Authority decision that is perceived by the ~~CCO~~MCE to adversely affect the ~~CCO~~MCE and is not otherwise reviewed as a claim redetermination, a contested case, or client appeal. An example of such disputes includes, but is not limited to, Authority decisions made through the OHA Provider Discrimination Review Process as a result of a provider discrimination appeal~~.~~;

(b) This rule does not address claims that the Authority has breached its contract with ~~a CCO.~~ an MCE;

(c) This ~~CCO~~MCE process is not mandatory, and it need not be exhausted before ~~a CCO~~an MCE seeks judicial review or brings any other form of action related to any ~~CCO~~MCE/Authority dispute related decision.

(2) Within ~~thirty~~30 calendar days of the conclusion of the administrative review, or such other time as may be agreed to by the ~~CCO~~MCE and the Authority, the Authority shall send written results of the administrative review to the initiating ~~CCO~~MCE and any other affected ~~CCO~~MCE. Should a resolution be reached through administrative review that is mutually agreeable to all involved, the process shall be considered complete and binding.

(3) If the dispute between the ~~CCO~~MCE and the Authority remains unresolved as a result of the administrative review, the CCO may request an alternative dispute resolution as set forth below to attempt to resolve the issue. The alternative dispute process is conducted pursuant to the Attorney General's Uniform Model Rules OAR 137-005-0060 and 137-005-0070.

(4) Not more than ~~ten~~10 business days after receipt of the final administrative review decision, the ~~CCO~~MCE may contact the Director of the Authority indicating the ~~CCO~~MCE's intent to pursue mediation. In that request, the ~~CCO~~MCE may request to stay the administrative review decision, which the Authority will grant if the ~~CCO~~MCE alleges sufficient facts and provides good cause for the stay as provided in OAR 137-004-0090. The Authority shall respond within ~~ten~~10 business days of the date of the stay request.

(5) After both the ~~CCO~~MCE and the Authority agree to enter into mediation, both shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the ~~CCO~~MCE and the Authority are unable to agree on the selection of a mediator, both shall appoint a mediator, and those mediators shall select the final mediator. To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(a) Be a knowledgeable and experienced mediator;

(b) Be familiar with health care and the disputed matters; and
(c) Follow the terms and conditions specified in this rule for the mediation process.

(6) If the dispute is likely to impact another ~~CCO~~MCE, the Authority shall notify all ~~CCOs~~MCEs potentially impacted by the dispute and provide an opportunity for the impacted ~~CCOs~~MCEs to participate in the dispute resolution process. ~~CCOs~~MCEs that opt into the process have, from that time forward, the same rights and responsibilities as the ~~CCO~~MCE that initiated the dispute.

(7) The ~~CCO~~MCE and the Authority shall share in the cost of all mediation expenses, whether the dispute is resolved or not.

(8) Within ~~ten~~10 business days of a selection of a mediator or upon a different schedule, as agreed to by the parties and the mediator, the ~~CCO~~MCE and the Authority shall submit to each other and to the mediator the following:

(a) Dispute resolution offer; and

(b) Explanation of their position, i.e., advocacy brief.

(9) The parties will engage in mediation as arranged by the mediator.

(10) The Authority shall maintain the confidentiality of proprietary information of all participating ~~CCOs~~MCEs to the extent the information is protected under state or federal law.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 183.484, 183.502 & 413.042

410-141-3555 Resolving Disputes between Health Care Entities and CCOs that Concern CCO ~~Contact~~Contract Award

(1) The dispute resolution process described in this rule applies only when, under ORS 414.635:

(a) An entity is applying to the Authority for contract award as a CCO (applicant);

(b) A Health Care Entity (HCE) and the applicant (together, the "parties" for purposes of this rule) have failed to agree upon terms for a contract; and

(c) One or more of the following occurs:

(A) The applicant states that the HCE is necessary for the applicant to qualify as a CCO;

(B) An HCE states that its inclusion is necessary for the applicant to be awarded a CCO; or

(C) In reviewing the applicant's information, the Authority identifies the HCE as necessary for the applicant to qualify as a CCO.

(2) If an applicant and HCE disagree about whether the HCE is necessary for the successful award of a contract to the applicant as a CCO, the applicant or HCE may request the Authority to review the issue.

(3) If the Authority determines the HCE is not necessary for the applicant's award of a contract, the process described in this rule does not apply.

(4) If the Authority determines or the parties agree the HCE is necessary for the applicant's award of a contract, the following applies:

(a) The HCE and the applicant shall participate in good faith contract negotiations. The parties shall take the following actions in an attempt to reach a good faith resolution:

(A) The applicant shall provide a written offer of terms and conditions to the HCE. The HCE shall explain the area of disagreement to the applicant;

(B) The applicant's or HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or applicant shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement.

(b) The applicant or HCE may request the Authority to provide technical assistance. The Authority also may offer technical assistance, with or without a request. The Authority's technical assistance is limited to clarifying the CCO contracting process, criteria, and other program requirements.

(5) Pursuant to ORS 414.635, if the applicant and HCE cannot reach agreement on contract terms within ~~ten~~10 calendar days of the face-to-face meeting, either party may request arbitration. The

requesting party shall notify the other party in writing to initiate a referral to an independent third-party arbitrator for an HCE's refusal to contract with the CCO or the termination, extension, or renewal of a HCE's contract with a CCO. The party initiating the referral shall provide a copy of the notification to the Authority.

(6) After notification that one party-initiated arbitration, the parties shall attempt to agree upon the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator.

(7) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay.

(8) Within ~~ten~~10 calendar days of a referral to an arbitrator, the applicant and HCE shall submit to each other and to the arbitrator the following:

(a) The most reasonable contract offers; or

(b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.

(9) Within ~~ten~~10 calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party shall submit to the arbitrator and the other party the advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.

(10) The arbitrator shall apply the following standards when making a determination about whether an HCE reasonably or unreasonably refused to contract with the applicant:

(a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers, and tribal health centers; and

(b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the health system transformation legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:

(A) Whether contracting with the applicant would impose demands that the HCE cannot reasonably meet without significant negative impact on HCE costs, obligations, or structure while considering the proposed reimbursement arrangement or other CCO requirements. Some of the requirements include:

(i) Use of electronic health records;

(ii) Service delivery requirements, or

(iii) Quality or performance requirements~~;~~.

(B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant shall make a good faith effort to work out differences in order to achieve beneficial community objectives and health system transformation policy objectives;

(C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant and that participation significantly reduces the HCE's capacity to contract with the applicant.

(11) The following outlines the arbitrator determination and the parties' final opportunity to settle:

(a) The arbitrator shall evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;

(b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for ~~ten~~10 calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the tenth day, the arbitrator may not release the determination to the Authority;

(c) If the parties have not reached an agreement after ~~ten~~10 calendar days, the arbitrator shall provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.

(12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:

(a) The Authority may award a contract to an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;

(b) The Authority may refuse to award a contract to an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from the HCE remains necessary for applicant's award of a contract as a CCO;

(c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant. This applies to health services available through a CCO;

(d) In any circumstance within the scope of this rule when the parties have failed to agree, the current statutes regarding reimbursement to non-participating providers shall apply to CCOs that hold contracts with OHA and the HCE, consistent with ORS 414.743 for hospitals and consistent with Authority rules for other providers.

(13) To be qualified to resolve disputes under this rule, the arbitrator shall:

(a) Be a knowledgeable and experienced arbitrator;

(b) Be familiar with health care provider contracting matters;

(c) Be familiar with health system transformation; and

(d) Follow the terms and conditions specified in this rule for the arbitration process.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3560 Resolving Contract Disputes Between Health Care Entities and CCOs

(1) Pursuant to ORS 414.635, Coordinated Care Organizations (CCOs) and Health Care Entities (~~HCE~~HCEs) shall participate in good faith contract negotiations. This rule covers the termination, extension, and renewal of an HCE's contract with a CCO.

(2) In the event of a dispute involving the termination, extension, or renewal of an HCE's contract with a CCO, the parties may take the following actions in an attempt to reach a good faith resolution:

(a) Both parties shall provide a written offer of terms and conditions to the other party. The parties shall explain the basis for their disagreement with the terms and conditions offered by the other party;

(b) The CCO's and HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or CCO shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement;

(c) The CCO or HCE may request the Authority to provide technical assistance. The Authority's technical assistance is limited to clarifying the CCO contractual provisions, subcontracting criteria, current reimbursement requirements, access standards, and other legal requirements.

(3) If the CCO and HCE cannot reach agreement on contract terms, the parties may engage in mediation. Either the CCO or the HCE may request mediation:

(a) After the parties have agreed to enter into mediation, the parties shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the parties are unable to agree, each party shall appoint a mediator, and those mediators shall select the final mediator;

(b) To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(A) Be a knowledgeable and experienced mediator;

(B) Be familiar with health care and contracting matters; and

(C) Follow the terms and conditions specified in this rule for the mediation process.

(c) The parties shall pay for all mediation costs, whether a conclusion is reached or not. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the mediator to allocate costs between the parties based on the ability to pay;

(d) Within ~~ten~~10 business days of a selection of a mediator, the CCO and HCE shall submit to each other and to the mediator the following:

(A) Contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) Unless an extension is agreed on by all parties, the mediator shall issue a report to the involved parties that will include mediation findings and recommendations no longer than 15 business days from the conclusion of the mediation.

(4) Pursuant to ORS 414.635, if the CCO and HCE cannot reach an agreement on contract terms within ten business days of receipt of the mediator's report, either party may request non-binding arbitration. The requesting party shall notify the other party in writing of the party's intent to refer the matter to arbitration:

(a) After notification that one party-initiated arbitration, the parties shall agree on the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator;

(b) To be qualified to propose resolutions for disputes under this rule, the arbitrator shall:

(A) Be a knowledgeable and experienced arbitrator;

(B) Be familiar with health care provider contracting matters; and

(C) Follow the terms and conditions specified in this rule for the arbitration process.

(c) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay;

(d) Within ~~ten~~10 business days of a selection of an arbitrator, the CCO and HCE shall submit to each other and to the arbitrator the following:

(A) Final contract offers; and

(B) Explanation of their position (i.e., advocacy brief).

(e) The arbitrator shall evaluate the final offers and the advocacy briefs from each party and issue a non-binding determination within 15 business days of the receipt of the parties' submissions.

Statutory/Other Authority: ORS 414.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3565 Managed Care Entity Billing ~~(Revised 8/2/19)~~

(1) Providers shall submit all billings for MCE members in the following timeframes:

(a) Submit billings within no more than four months of the date of service for all cases, except as provided for in section (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

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

(A) Pregnancy;

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

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

(D) Other cases that delay the initial billing to the MCE, not including failure of the provider to verify the member's eligibility; or

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

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

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Authority programs and;

(b) Assigned to an MCE on the date of service.

(5) Providers shall use the Authority's and MCE's tools to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall

complete an OHP 3165 "OHP Client Agreement to Pay for Health Services," or facsimile signed by the client as described in OAR 141-120-1280.

(6) If a member has other insurance coverage available for payment of covered services, the insurance must be exhausted prior to payment for the covered services. Member cost-sharing incurred as part of other coverage shall be paid to the insurer by the MCE.

(7) MCEs shall pay for all covered services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. 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:

(a) A client may not be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(8) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider~~.~~:

(a) MCEs shall have written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify timeframes for:

(A) Date stamping claims when received;

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

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

(D) Sending written notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3885.

(b) MCEs shall pay or deny at least 90 percent of valid claims within 30 days of receipt and at least 99 percent of valid claims within 90 days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt;

(c) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3885;

(d) MCEs may not require providers to delay billing to the MCE;

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

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

(g) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(h) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis~~.~~;

(i) MCEs may not deny a claim for behavioral health services on the basis that such services were delivered in the member's home unless the MCE would deny a claim for comparable physical health services performed at the same site of service.

(9) MCEs shall pay for Medicare coinsurances and deductibles consistent with Oregon's State Plan methodology up to the Medicare or MCE's allowable for all Medicare Part A and Part B covered services the member receives from a Medicare enrolled provider after adjudication with Medicare or a Medicare Advantage plan~~.~~;

(a) ~~(a)~~ Providers must be enrolled in Oregon Medicaid to receive cost-sharing payments and non-enrolled providers should be given information on how to enroll to receive cost-sharing. Pursuant to OAR 410-120-1280(i), FFS Medicare providers should be encouraged to submit the Medicaid information necessary to enable electronic crossover to the MCE with their Medicare claims~~.~~ ;

~~(b)~~ (b) MCE and affiliated Medicare Advantage plan shall provide a process for automatic Medicare
to Medicaid crossover payments to ensure cost-sharing and reduce duplicate provider submission of claims~~.~~;

~~(c)~~ (c) Federal law bars Medicare providers and suppliers from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays~~.~~ ;

~~(d)~~ (d) MCE must inform providers of rules that prohibit balance billing and ensure providers serving and accepting plan payment for Qualified Medicare Beneficiaries mean members cannot be balance-billed per Sections 1902(n)(3) (C) and 1905 (p) (3) of the Social Security Act.

(10) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(11) MCEs shall pay for ancillary covered services provided by a non-participating provider under the following conditions:

(a) MCEs shall pay for ancillary covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

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

(B) The ancillary covered service was delivered in good faith without the prior authorization;

(C) The ancillary covered service would have been prior authorized with a participating provider if the MCE's referral procedures had been followed~~;~~.

(b) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in 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 OAR 410-141-3565 (12-14);

(c) Except as specified in OAR 410-141-3840 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(d) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(e) MCEs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies including but not limited to

pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements. MCE shall pay hospitals any applicable Qualified Directed Payments pursuant to OAR 410-125-0230.

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

(a) Sections (12) and (14) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

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

(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3555 and 410-141-3560;

(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(13) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" are not subject to determination via the algorithm and shall remain on CBR.

(14) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

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

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table on the Authority's website.

(15) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the MCE or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;

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

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;

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

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

(g) MCE's that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the MCE would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of Section 4712(b)(2) of the Balanced Budget Act of 1997.

(16) MCEs shall maintain a Coordination of Benefits Agreement that allows participation in the automated claims crossover process with Medicare for those members dually eligible for Medicaid and Medicare services.

(17) MCEs shall ensure providers under the MCE contract are notified of billing processes for crossover claims processing, as described in OAR 410-120-1280.

(18) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-3825 Excluded Services and Limitations for OHP Clients.

(19) MCEs shall engage in collaborative efforts with the Authority to achieve the requirements of the CCO Value-based Purchasing Roadmap.

Statutory/Other Authority: 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.065 & 414.610 - 414.685

410-141-3570 Managed Care Entity Encounter Claims Data Reporting

(1) MCEs ~~must~~shall meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Authority's 837 technical specifications for encounter data, and the Authority's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site.

(2) MCEs ~~must~~shall collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the MCE must utilize the HIPAA standards~~.~~:

(a) MCEs shall submit encounter claims for all ~~services, whether they are~~ covered services ~~or other~~, except for health-related services, provided to members as defined in OAR 410-120-0000 and 410-141-3500~~.~~;

(b) MCEs shall submit encounter claims data including encounters for:

(A) Services where the MCE determined that liability exists; even if the MCE did not make any payment for a claim;

(B) Services where the MCE determined that no liability exists~~, even if the MCE did not make any payment for a claim~~;

(C) Services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program;

(D) Paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the MCE, or the MCE's subcontractor; and

(E) Services to members who also have Medicare coverage, if a claim has been submitted to the MCE.

(c) MCEs shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare pursuant to 42 CFR 438.3(t);

(d) MCEs shall report encounter claims data whether the provider is an in-network participating or out-of-network, non-participating provider.

(3) MCEs ~~must~~shall follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

(4) MCEs ~~must~~shall submit all valid unduplicated encounter claims: professional, dental, institutional, and pharmacy within 45 days of the date of adjudication~~.~~:

(a) MCEs ~~must~~shall ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their web site or by contacting the National Council for Prescription Drug Programs organization;
(b) Submission Standards and Data Availability:

(A) MCEs ~~must~~shall only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the MCE by the Authority in encounter claims:

(i) The National Provider Identifiers (NPI) for a provider covered entity enrolled with the Authority; or

(ii) The Oregon Medicaid proprietary provider numbers for the Authority enrolled non-covered atypical provider entities.

(B) MCEs ~~must~~shall make an adjustment to any encounter claim within 30 days of discovering the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed;

(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) below, the MCE must adjust or void the encounter claim within ~~14~~30 days of notification by the Authority of the required action or as identified in paragraph (E) below;

(D) If the Authority discovers errors with a previously adjudicated encounter claim resulting from a federal or state mandate or request that requires the completeness and accuracy of the encounter data, the MCE must correct the errors within a timeframe specified by the Authority;

(E) If circumstances prevent the MCE from meeting requested timeframes for correction, the MCE may contact the Authority to determine an agreed upon specified date except as required in subsection (d) below;

(F) MCEs retain liability for certifying encounter data as complete, truthful, and accurate. MCEs must ensure claims data received from providers, either directly or through a third-party submitter, is accurate, truthful, and complete by:

(i) Verifying accuracy and timeliness of reported data;

(ii) Screening data for completeness, logic, and consistency;

(iii) Submitting a complete and accurate Encounter Data Certification and Validation Report available on the Authority's website.

(G) MCEs ~~must~~shall make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.

(c) Encounter Claims Data Corrections for "must correct" Encounter Claims:

(A) The Authority shall notify the MCE of the status of all encounter claims processed;

(B) Notification of all encounter claims processed that are in a "must correct" status shall be provided by the Authority to the MCE each week and for each subsequent week the encounter claim remains in a "must correct" status;

(C) The Authority may not necessarily notify the MCE of other errors; however, this information is available in the MCE's electronic remittance advice supplied by the Authority;

(D) MCEs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the MCE notice that the encounter claim remains in a "must correct" status.;

(E) MCEs may not delete encounter claims with a "must correct" status as specified in section (3)(d) except when the Authority has determined the encounter claim cannot be corrected or for other reasons.

(5) Electronic Health Records (EHR) Systems OAR 410-165-0000 to 410-165-0140. In support of an eligible provider's ability to demonstrate meaningful use as an EHR user, as described by 42 CFR 495.4 and 42 CFR 495.8, the MCE must:

(a) Submit encounter data in support of a qualified EHR user's meaningful use data report to the Authority for validation as set forth in OAR 410-165-0080;

(b) Respond within the timeframe determined by the Authority to any request for:

(A) Any suspected missing MCE encounter claims, or;

(B) MCE-submitted encounter claims found to be unmatched to an EHR user's meaningful use report.

(6) MCEs ~~must~~shall comply with the following hysterectomy and sterilization standards as described in 42 CFR 441.250 to 441.259 and the requirements of OAR 410-130-0580:

(a) MCEs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of the date of service; or immediately upon notification by the Authority that a qualifying encounter claim has been identified;

(b) The Authority in collaboration and cooperation with the MCE shall reconcile all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:

(A) Confirming the validity of the consent and notifying the MCE that no further action is needed;

(B) Requesting a corrected informed consent form, or;

(C) Informing the MCE, the informed consent is missing or invalid and the payment must be recouped, and the associated encounter claim must be changed to reflect no payment made for services within the timeframe set by the Authority.

(7) Upon request by the Authority, MCEs ~~must~~shall furnish information regarding rebates for any covered outpatient drug provided by the MCE as follows:

(a) The Authority is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8) as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) for any covered outpatient drug provided by the MCE, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;

(b) MCEs shall report prescription drug data as specified in section (3)(b).

(8) Encounter Pharmacy Data Rebate Dispute Resolution as governed by SSA Section 1927 42 U.S.C. 1396r-8 and as required by OAR 410-121-0000 through 410-121-0625. When the Authority receives an Invoiced Rebate Dispute from a drug manufacturer, the Authority shall send the Invoiced Rebate Dispute to the MCE for review and resolution within 15 days of receipt:

(a) The MCE shall assist in the dispute process as follows:

(A) By notifying the Authority that the MCE agrees an error has been made; and

(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 days of receipt of the Invoiced Rebate Dispute.

(b) If the MCE disagrees with the Invoiced Rebate Dispute that an error has been made, the MCE shall send the details of the disagreement to the Authority's encounter data liaison within 45 days of receipt of the Invoiced Rebate Dispute.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3575 MCE Member Relations: Marketing

(1) The following definitions apply for purposes of OAR 410-141-3575 through 410-141-3585:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. This term includes, at a minimum, the types of alternate formats defined under the Americans with Disabilities Act (ADA) and 45 CFR Part 92, and shall include: braille, large (18 point) print, audio narration, oral presentation, electronic file, sign language interpretation, and sighted guide~~.~~;

(b) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the MCE~~.~~;

(c) "Marketing" means any communication from an MCE to a potential member who is not enrolled in the MCE that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE~~.~~;

(d) "Marketing Materials" means materials that are produced in any medium by or on behalf of an MCE and that can reasonably be interpreted as intended to market to potential members~~.~~;

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

(f) "Outreach Materials" means materials that are produced in any medium, by or on behalf of an MCE that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE~~.~~;

(g) "Potential Member" means, as defined in OAR 410-141-3500, a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE~~.~~;

(h) "Prevalent Non-English Language" means all non-English languages that are identified during the eligibility process as the preferred written language by either:

(~~a~~A) Five percent of the MCE's total OHP enrollment; or

(~~b~~B) One thousand of the MCE's members~~.~~;

(i) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

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

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

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

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

(3) The following ~~communications with~~outreach to members or potential members are expressly permitted:

(a) The creation of name recognition by an MCE. Permissible methods for creating name recognition include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health-related events~~.~~;

(b) ~~A~~An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors, so long as the communications do not constitute an attempt to compel or entice a client's enrollment~~.~~;

(c) The following communications related to dual-eligible members, as long as they do not constitute an attempt by the MCE to influence client enrollment:

(A) Communications to notify dual-eligible members of opportunities to align MCE-provided benefits with Medicare Advantage or Special Needs Plans;

(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.

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

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

(6) MCEs shall comply with the Authority's marketing materials guidelines or other requirements for the submission, approval, review and correction of marketing materials or other communications with members or potential members. MCEs shall participate, as required, in development of guidelines or other requirements with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

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

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

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

~~(d~~

(c) A marketing materials submission form to ensure compliance with MCE marketing rules; and

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

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3580 MCE Member Relations: Potential Member Information

(1) In addition to the requirements below, information for potential members shall comply with the marketing requirements and prohibitions in 42 CFR § 438.104 and OAR 410-141-3575 and any requirements or guidelines adopted by the Authority there under .

(2) MCEs shall develop informational materials for potential members and provide such materials to the Authority. An MCE or the Authority may include informational materials in the application packet for potential members.

(3) MCEs' informational materials shall be sufficient for the potential member to make an informed decision about provider selection.

(4) The MCE shall make available to potential members, upon request, information on participating providers. MCE provider directories for potential members shall include all specified elements and be made readily accessible as defined in 42 CFR 438.10.

(5) MCEs' informational materials shall include the following information for potential members regarding the rights of American Indians and Alaskan Natives:

(a) MCEs' informational materials shall state that American Indians and Alaskan Natives enrolled in the MCEs may select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE, insofar as the individual is otherwise eligible to receive primary care services from such IHCP and the IHCP has the capacity to provide primary care services to such ~~Indian~~American Indians and Alaskan Natives.

(b) MCEs shall clearly explain to potential members that American Indians and Alaskan Natives enrolled in an MCE shall also be permitted to obtain primary care services covered under the contract between the state and MCE from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive primary care services. Prior authorization to receive services from an IHCP may not be permitted solely based on criteria that the provider is an IHCP or out of network, and American Indians and Alaskan Natives may be referred by out-of-network IHCPs to a network provider without prior authorization or referral from a participating provider.

(6) MCEs' informational materials for potential members in their service area shall meet the following language requirements:

(a) Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English~~.~~;

(b) MCEs shall ~~honor~~accommodate requests made by potential members, potential members' family members, or potential members' caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include but are not limited to 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.

(c) MCEs shall address health literacy issues by preparing informational materials at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a minimum 12-point font or large print (18 point). MCEs shall make written informational materials available in alternative formats upon request of the potential member at no cost. Auxiliary aids and services and interpreter services must also be made available upon request of the potential member at no cost.

(7) MCEs shall ensure that all staff who have contact with potential members are:

(a) Fully informed of MCE and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free qualified or certified health care interpreters in any language required by the member including American Sign Language, and the process for requesting auxiliary aids or alternative format materials~~.~~;

(b) Able to assist members in determining which participating providers:

(A) Have capacity in languages other than English;

(B) Have offices/facilities that are accessible and have accommodations for people with physical disabilities, including but not limited to offices, exam rooms, restrooms and equipment; and

(C) Are accepting new members.

(c) Trained in cultural competency and trauma-informed care, as those terms are defined in OAR 309-035-0105 and in accordance with CCO Health Equity Plan Training and Education plan described in 410-141-~~AAAA SDOH/HE (4) (b)~~3735.

(8) MCE staff shall be able to provide potential members with information on how to access the Authority Beneficiary Support System, including information for dual-eligible members on how to receive choice counseling on Medicaid and Medicare options as required in 42 CFR 438.71.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3585 MCE Member Relations: Education and Information

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE 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.

(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination 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. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages in its particular service area ~~MCE~~. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs 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 how to access intensive care coordination (ICC) Services, and where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10~~.~~;

(c) Inform all members of the availability of Ombudsperson services.

(5) Written member education materials shall comply with the following language and access requirements:

(a) Materials shall be translated or include taglines in the prevalent non-English languages in the state as well as large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;

(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings~~.~~:

(c) Electronic versions of member materials shall be made available on MCE website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the MCE shall provide it upon request within five business days.

(6) MCE provider directories shall include:

(a) The provider's name as well as any group affiliation;

(b) Street address;

(c) Telephone number;

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

(g) Information about the provider's cultural and linguistic capabilities including:

(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;

(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and

(C) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in

410-141- ~~AAAA SDOH/HE (4) (b)~~3735 whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);

(D) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment.

(h) The information for each of the following provider types covered under the contract, as applicable to the MCE contract:

(A) Physicians, including specialists;

(B) Hospitals;

(C) Pharmacies;

(D) Behavioral health providers; including specifying substance use treatment providers;

(E) Dental providers.

(i) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format;

(j) Each MCE shall make available in electronic or paper form the following information about its formulary:

(A) Which medications are covered both generic and name brand;

(B) What tier each medication is on.

(7) Within 14 days or a reasonable timeframe of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 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.

(8) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.

(9) MCEs must notify enrollees:

(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and

(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;

(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.

(10) An MCE shall electronically provide to the Authority 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 alternate formats.;

(c) MCE's office location, mailing address, web address, 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 MCE'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) Which 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 ICC services and how eligible members may access those services;

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, 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~~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 MCE's grievance and appeals processes and the Authority's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the MCE to the member as outlined in OAR 410-141-3875;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3885.

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsperson;

(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCE network for non-emergent care; including information specific to deductibles, copays 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 MCE'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 MCE uses provider contracts including alternative payment methodologies or incentives;

(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 and scheduling process for use of non-emergency medical transportation (NEMT) services;

(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;

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

(aa) The MCE's confidentiality policy;

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

(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs;

(dd) MCEs 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 MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members;

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

(11) 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. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort 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 MCEs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:

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

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

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

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

(d) ~~Explanation~~An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC-related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTCSS;

(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) MCEs 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 MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.

(12) MCEs shall provide an identification card to members, unless waived by the Authority, 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 MCE, members, and providers.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3590 MCE Member Relations: Member Rights and Responsibilities

(1) MCEs shall:

(a) Have written policies and procedures that ensure that members have the rights and responsibilities included in this rule;

(b) Communicate these policies and procedures to participating providers;

(c) Monitor compliance with these policies and procedures, take corrective action as needed, and report findings to the Quality Improvement Committee defined under OAR 410-141-3525.

(2) MCE members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

(b) Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;

(c) Choose a Primary Care Provider (PCP) or service site and to change those choices as permitted in the MCE's administrative policies;

(d) Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;

(e) Have a friend, family member, member representative, or advocate present during appointments and other times as needed within clinical guidelines;

(f) Be actively involved in the development of their treatment plan;

(g) Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;

(h) Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;

(i) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(j) Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

(k) Receive culturally and linguistically appropriate services and supports in locations as geographically close to where members reside or seek services as possible and choice of

providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

(~~l~~L) Receive oversight, care coordination and transition and planning management from their MCE within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

(m) Receive necessary and reasonable services to diagnose the presenting condition;

(n) Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

(o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

(p) Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters , certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(q) Obtain covered preventive services;

(r) Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;

(s) Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in the MCE's referral policy;

(t) Have a clinical record maintained that documents conditions, services received, and referrals made;

(u) Have access to one's own clinical record, unless restricted by statute;

(v) Transfer of a copy of the clinical record to another provider;

(w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;

(x) Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;

(y) Be able to make a complaint or appeal with the MCE and receive a response;

(z) Request a contested case hearing;

(aa) Receive certified or qualified health care interpreter services; and

(bb) Receive a notice of an appointment cancellation in a timely manner;

(cc) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

(3) CCO members shall have the following responsibilities:

(a) Choose or help with assignment to a PCP or service site;

(b) Treat the MCE, provider, and clinic staff members with respect;

(c) Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;

(d) Seek periodic health exams and preventive services from the PCP or clinic;

(e) Use the PCP or clinic for diagnostic and other care except in an emergency;

(f) 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) Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in the MCE's referral policy;

(h) Give accurate information for inclusion in the clinical record;

(i) Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;

(j) Ask questions about conditions, treatments, and other issues related to care that is not understood;

(k) Use information provided by MCE providers or care teams to make informed decisions about treatment before it is given;

(~~l~~L) Help in the creation of a treatment plan with the provider;

(m) Follow prescribed agreed upon treatment plans and actively engage in their health care;

(n) Tell the provider that the member's health care is covered under the OHP before services are received and, if requested, show the provider the Division Medical Care Identification form;

(o) Tell the Department or Authority worker of a change of address or phone number;

(p) Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child;

(q) Tell the Department or Authority worker if any family members move in or out of the household;

(r) Tell the Department or Authority worker if there is any other insurance available;

(s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(t) Pay the monthly OHP premium on time if so required;

(u) Assist the MCE in pursuing any third-party resources available and reimburse the MCE the amount of benefits it paid for an injury from any recovery received from that injury; and

(v) Bring issues or complaints or grievances to the attention of the MCE.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3600 MCE Assessment: Definitions

The following definitions apply for purposes of OAR 410-141-3600 through 3655:

(1) "Deficiency" means the amount by which the assessment as correctly computed exceeds the assessment, if any, reported by the managed care entities (MCEs).

(2) "Delinquency" means the MCE failed to file a report when due or to pay the assessment as correctly computed when the assessment was due.

(3) “MCE Assessment”means the managed care assessment defined under OAR 410-141-3610.

(4) “Recoupment”means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

Statutory/Other Authority: ORS 413.042 & ORS 414.025
Statutes/Other Implemented: ORS 414.065 & 2017 HB 2391

410-141-3601 MCE Assessment: General Administration

(1) The purpose of these rules is to govern the administration, enforcement, and collection of the managed care assessment on MCEs.

(2) MCEs shall pay an assessment on the gross amount of premium equivalents received during a calendar quarter.:

(a) The MCE assessment rate for the period beginning January 1, 2018 and ending December 31, 2019, is 1.5 percent.:

(b) The MCE assessment rate for the period beginning January 1, 2020 and ending December 31, 2026, is 2 percent.

(3) MCE assessments imposed are in addition to and not in lieu of any assessment, surcharge, or other assessment imposed on an MCE.

(4) The Authority may develop forms and reporting requirements and change the forms and reporting requirements as necessary to administer, enforce, and collect the assessments.

Statutory/Other Authority: ORS 413.042 & ORS 414.025
Statutes/Other Implemented: ORS 414.065 & 2017 HB 2391

410-141-3605 MCE Assessment: Disclosure of Information

(1) Except as otherwise required by law, the Authority may not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the assessments. Particulars include but are not limited to social security numbers, employer numbers, or other organization identification numbers, and any business records required to be submitted to or inspected by the Authority to allow it to determine the amount of any assessments, delinquencies, or deficiencies payable or paid, or otherwise administer, enforce, or collect a health care assessment to the extent that the information would be exempt from disclosure under ORS 192.345(5).

(2) The Authority may:

(a) Upon request, furnish any MCE or its authorized representative with a copy of the MCE's report filed with the Authority for any quarter, or with a copy of any other information filed by the MCE in connection with the report, or as the Authority considers necessary;

(b) Publish information or statistics so classified as to prevent the identification of income or any particulars contained in any report or return; and

(c) Disclose and give access to an officer or employee of the Authority or its designee, or to the authorized representatives of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Controller General of the United States, the Oregon Secretary of State, the Oregon Department of Justice, the Oregon Department of Justice Medicaid Fraud Control Unit, and other employees of the state or federal government unless the Authority deems disclosure or access necessary or appropriate for the performance of official duties in the Authority's administration, enforcement, or collection of these assessments.

Statutory/Other Authority: ORS 413.042 & ORS 414.025
Statutes/Other Implemented: ORS 414.065 & 2017 HB 2391

410-141-3610 MCE Assessment: Calculation, Report, Due Date, Verification

(1) The MCE assessment on the premium equivalents paid to an MCE on or after January 1, 2018, is based on calendar quarters. Calendar quarter start dates are January 1, April 1, July 1, and October 1. For purposes of this rule, premium equivalents shall be assessed as of the calendar quarter in which the premium equivalents are received by the MCE.

(2) Premium equivalents include all capitation payments received by the MCE for the provision of health services and all other payments received by the MCE from the Authority for providing health services under ORS chapter 414, including maternity payments, quality incentive pool payments, and qualified directed payments as defined in OAR 410-125-0230. Premium equivalents do not include Medicare premiums or any form of payment by Oregon Health Plan (OHP) enrollees.

(3) Adjustments to premium equivalents subject to assessment shall be determined as follows:

(a) Premium equivalents attributable to periods prior to January 1, 2018, except annual quality incentive pool payments, are not subject to the assessment and shall be deducted from the assessable premium equivalents when calculating the assessment due;

(b) Adjustments due to changes in client status and other premium equivalents adjustments resulting in additional payments received by the MCE on or after April 1, 2018, are subject to the assessment;

(c) If premium equivalents are reduced by a recoupment by the Authority for an overpayment, then the assessable premium equivalents shall be the reduced amount after recoupment;

(d) If both an overpayment and recoupment occur, the MCE shall be subject to the assessment on the premium equivalents received in the calendar quarter; and

(e) Sub-capitation payments made to an MCE by another MCE are not included in the total premium equivalents subject to assessment if the paying MCE certifies to the receiving MCE in writing that the paying MCE is already responsible for the managed care assessment on the originating premium equivalents.

(4) The MCE must pay the MCE assessment and file the report on a form approved by the Authority on or before the 45th day following the end of the calendar quarter for which an assessment is due unless the Authority permits a later payment date. The MCE must provide all required information on the report.

(5) Any report, statement, or other document required to be filed shall be certified by the MCE's chief financial officer or designee. The certification must attest, based on best knowledge, information, and belief to the accuracy, completeness, and truthfulness of the document.

(6) Payments may be made electronically or by paper check. If the MCE pays electronically, the accompanying report may either be faxed or mailed to the Authority. If the MCE pays by paper

check, the accompanying report must be mailed with the check to the address provided on the report form.

(7) The Authority may charge the MCE a fee of $100 if for any reason the check, draft, order, or electronic funds transfer request is dishonored. This charge is in addition to any penalty for nonpayment of the assessments that may also be due.

Statutory/Other Authority: ORS 413.042 & ORS 414.025
Statutes/Other Implemented: ORS 414.065 & 2017 HB 2391

410-141-3615 MCE Assessment: Filing an Amended Report

(1) The claims for refunds or payments of additional MCE assessment must be submitted by the MCE on an Authority approved form. The MCE must provide all information required on the report. The Authority may audit the MCE, request additional information, or request an informal conference prior to granting a refund or as part of its review of a payment of a deficiency.

(2) Claim for refund:

(a) If the amount of the MCE assessment imposed is less than the amount paid by the MCE and the MCE does not then owe an assessment for any other calendar period, the Authority may refund the overpayment. In no event shall a refund applicable to a particular calendar quarter exceed the assessment amount actually paid by the MCE;

(b) The MCE may file a claim for refund on an Authority approved form within 180 days after the end of the calendar quarter to which the claim for refund applies;

(c) If there is an amount due from the MCE to the Authority for any past due assessments or penalties, any refund otherwise allowable shall first be applied to the unpaid assessments and penalties, and the Authority shall notify the MCE.

(3) Payment of deficiency:

(a) If the amount of the MCE assessment is more than the amount paid by the MCE, the MCE may file a corrected report and pay the deficiency at any time. The penalty under OAR 410-141-3635 shall stop accruing after the Authority receives full payment of the total deficiency for the calendar quarter;

(b) If there is an error in the determination of the assessment due, the MCE may describe the circumstances of the late additional payment with the late filing of the amended report. The Authority, in its sole discretion, shall determine the penalty for such late additional payments pursuant to OAR 410-141-3635.

(4) If the Authority discovers or identifies information that it determines could give rise to the issuance of a notice of proposed action or the issuance of a refund, the Authority shall issue notification pursuant to OAR 410-141-3640.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 2017 HB 2391

410-141-3620 MCE Assessment: Determining the Date Filed

(1) For the purposes of these rules, any reports, requests, appeals, payments, or other response by the MCE must be either:

(a) Received by the Authority before the close of business on the date due; or

(b) If mailed, postmarked before midnight of the due date.

(2) When the due date falls on a Saturday, Sunday, or legal holiday, the response is due on the next business day.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065

410-141-3625 MCE Assessment: Authority to Audit Records

(1) The MCE must maintain financial records necessary and adequate to determine the amount of premium equivalents for any period for which an MCE assessment may be due.

(2) The Authority may audit the MCE's records at any time for a period of five years following the date the assessment is due to verify or determine the premium equivalents for the MCE.

(3) Any audit, finding, or position may be reopened if there is evidence of fraud, malfeasance, concealment, misrepresentation of material fact, omission of income, or collusion either by the MCE or by the MCE and an Authority representative.

(4) The Authority may notify the MCE of a potential deficiency or issue a refund based upon its audit findings.

Statutory/Other Authority: ORS 413.042 & ORS 414.025
Statutes/Other Implemented: ORS 414.065 & 2017 HB 2391

410-141-3630 MCE Assessment: Determining Assessment Liability on Failure to File

~~(1)~~ (1) In the case of a failure by the MCE to file a report or to maintain necessary and adequate records, the Authority shall determine the MCE assessment liability according to the best of its information and belief.

~~(2)~~ (2) Best of its information and belief means the Authority shall use evidence available to the Authority at the time of the determination on which a reasonable person would rely on to determine the assessment.

~~(3)~~ (3) The Authority's determination of assessment liability shall be the basis for the assessment due in any notice of proposed action.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3635 MCE Assessment: Financial Penalty for Failure to File a Report or Failure to Pay Assessment When Due

(1) An MCE that fails to file a report or pay an MCE assessment in full when due is subject to a penalty of up to $500 per day of delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(2) The total amount of penalty imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which the penalty is being imposed.

(3) In determining the amount of the penalty, the Authority shall consider evidence, such as:

(a) The MCE's history of prior late payments and prior penalties;

(b) The MCE's actions to come into compliance;

(c) The occurrence of unforeseeable circumstances against which it would have been unreasonable for the MCE to take precautions and which the MCE cannot avoid even by using its best efforts. Such circumstances include, but are not limited to, a natural disaster (e.g., earthquakes, floods, tornadoes), fires, an act of war (e.g., hostilities, invasion, terrorism, civil disorder), or other circumstances not within the reasonable control of the MCE;

(d) In the case of a deficiency due to an error when the MCE files a timely original return and pays the assessment identified in the return, the nature and extent of the error, evidence of prior errors, and the MCE's explanation of the circumstances related to the error.

(4) The Authority shall collect any penalties imposed under this section and deposit the funds in the Health System Fund.

(5) Penalties paid under this section are in addition to the MCE assessment.

(6) If the Authority determines that an MCE is subject to a penalty under this section, the Authority shall issue a notice of proposed action as described in OAR 410-141-3640.

(7) If an MCE requests a contested case hearing, the Director of the Authority, at the Director's sole discretion, may reduce the amount of penalty assessed.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3640 MCE Assessment: Notice of Proposed Action

(1) Prior to issuing a notice of proposed action, the Authority shall notify the MCE of a potential deficiency or failure to report that could give rise to the imposition of a penalty. The Authority shall issue a 30-day notification letter within 30 calendar days of the report or payment due date. The MCE shall have 30 calendar days from the date of the notice to respond. The Authority may consider the response, if any, and any amended report under OAR 410-141-3615 in its notice of proposed action. In all cases that the Authority has determined that ~~a~~an MCE has an MCE assessment deficiency or failure to report, the Authority shall issue a notice of proposed action. The Authority may not issue a notice of proposed action if the issue is resolved satisfactorily within 59 days from the date of mailing the 30-day notification letter.

(2) The Authority shall issue a notice of proposed action within 60 calendar days from the date of mailing the 30-day notification letter.

(3) Contents of the notice of proposed action must include:

(a) The applicable calendar quarter;

(b) The basis for determining the corrected amount of assessment for the quarter;

(c) The corrected assessment due for the quarter as determined by the Authority;

(d) The amount of assessment paid for the quarter by the MCE;

(e) The resulting deficiency, which is the difference between the amount received by the Authority for the calendar quarter and the corrected amount due as determined by the Authority;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of delinquency;

(h) Date upon which the penalty began to accrue;

(i) Date the penalty stopped accruing or circumstances under which the penalty will stop accruing;

(j) The total penalty accrued up to the date of the notice;

(k) Instructions for responding to the notice; and

(~~l~~L) A statement of the MCE's right to a hearing.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3645 MCE Assessment: Hearing Process

(1) Any MCE that receives a notice of proposed action may request a contested case hearing pursuant to ORS 183.411 through 183.500.

(2) The MCE may request a hearing by submitting a written request within 20 days of the date of the notice of proposed action.

(3) Prior to the hearing, the MCE shall meet with the Authority for an informal conference:

(a) The informal conference may be used to negotiate a written settlement agreement;

(b) If the settlement agreement includes a reduction or waiver of penalties, the agreement must be approved and signed by the Director of the Authority.

(4) Except as provided in section (5) of this rule, if the case proceeds to a hearing, the administrative law judge shall issue a proposed order with respect to the notice of proposed action. The Authority shall issue a final order.

(5) Nothing in this section shall preclude the Authority and the MCE from agreeing to informal disposition of the contested case at any time.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3650 MCE Assessment: Final Order of Payment

~~(1)~~ The Authority shall issue a final order of payment for deficiencies or penalties when:

(~~a~~1) The MCE did not make a timely request for a hearing~~.~~;

(~~b~~2) Any part of the deficiency or penalty was upheld after a hearing~~.~~;

(~~c~~3) Upon agreement of the MCE and the Authority.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3655 Assessment: Remedies Available after Final Order of Payment

~~(1)~~ Any amounts due and owing under the final order of payment and any interest thereon may be recovered by Oregon as a debt to the state, using any available legal and equitable remedies which include but are not limited to:

(~~a~~1) Collection activities including but not limited to deducting the amount of the final deficiency or penalty from any sum then or later owed to the MCE by the Authority~~.~~;

(~~b~~2) Every payment obligation shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the final order of payment and continuing until the payment obligation, including interest, has been discharged.

Statutory/Other Authority: 413.042 & 414.025
Statutes/Other Implemented: 414.065 & 2017 HB 2391

410-141-3700 CCO Application and Contracting Procedures

(1) The Authority shall establish an application process for entities seeking contracts as CCOs, in conformity with this OAR 410-141-3700 and OAR 410-141-3705. The following definitions apply with respect to that application process:

(a) "Applicant" means the entity submitting an application to be a CCO, or to enter into or amend a contract for coordinated care services.;

(b) "Application" means an applicant's written response to a Request for Applications.;

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

(2) The Authority shall use the following RFA processes for CCO procurement and contracting:

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

(b) The RFA process shall begin with a public notice that shall be communicated using the Oregon Procurement Information Network (ORPIN) website. A public notice of an RFA shall identify the services the Authority is seeking, the designated service areas where services are requested, a sample contract, and how potential applicants can keep informed of RFA updates;

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

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

(e) The RFA shall include, at a minimum, the elements required under OAR 410-141-3705, and shall request information from applicants to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

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

(3) Readiness Reviews:

(a) The Authority shall have discretion whether to have a readiness review process unless otherwise required by law and require successful completion of the readiness review as a condition to contracting;

(b) If the Authority chooses to have a readiness review process and require successful completion as a condition to contracting, the process shall be described in the underlying procurement document or otherwise communicated to respondents during the procurement process;

(c) Readiness review shall include those areas required by law and may also include other topics identified by the Authority;

(d) The Authority reserves the right to request to provide updated information gleaned during the readiness review process throughout the term of the resulting contract as needed for compliance monitoring and performance reviews.

(4) The Authority shall determine that organizations meet the criteria for being CCOs as follows:

(a) The Authority shall issue CCO contracts only to applicants that meet the criteria in OAR 410-141-3705, meet the RFA requirements, and provide the assurances specified in the RFA. The Authority shall determine if the applicant qualifies for being a CCO based on the application and any additional information and investigation that the Authority may require;

(b) The Authority shall notify each applicant that applies for CCO status if it meets the criteria for being a CCO;

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

(A) For members and potential members, optimize access to care and choice of providers, and where possible choice among CCOs;

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

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

(d) The Authority may determine that an applicant is potentially eligible for a CCO contract in accordance with paragraph (f) below. The Authority is not obligated to determine whether an applicant is potentially eligible for a CCO contract if, in its discretion, the Authority determines that sufficient applicants eligible for a CCO contract are available to attain the Authority's objectives under the RFA;

(e) The Authority may determine that an applicant is potentially eligible for a CCO contract if:

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

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

(C) If the Authority determines that an applicant potentially eligible for a CCO contract does not meet the criteria for a CCO contract within the time announced in the RFA for contract award, the Authority may:

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

(ii) Inform the applicant that it is not eligible for a CCO contract.

(f) The Authority shall enter into a new contract or contract renewal with a CCO only if the CCO meets the criteria for being a CCO and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes but is not limited to:

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

(B) The number of CCOs in the region.

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

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

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

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

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

(6) Disclosure of application contents and release of information.:

(a) Except for the letter of intent to apply, information may not be disclosed to any applicant or the public until the award date, unless otherwise specified in the RFA and allowed by law. The "award date" refers to the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts. No information may be given to any applicant or the public relative to its standing with other applicants before the award date except under the following circumstances:

(A) The information in the application may be shared with the Authority, DCBS, Oregon Health Insurance Marketplace, PEBB, OEBB, PERS, CMS, and those individuals involved in the application review and evaluation process; and

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

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

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

(8) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on June 30, 2018) to govern RFAs and contracting with CCOs:

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

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

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

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

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

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules if the Authority requires certification as a condition to contract;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are incorporated herein;

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

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

Statutory/Other Authority: ORS 414.615, 414.625, 414.635, 414.651 & 413.042
Statutes/Other Implemented: ORS 414.610 - 414.685

~~-~~410-141-3705 Criteria for CCOs

(1) In administering the procurement process described in OAR 410-141-3700, the Authority shall require applicants to describe their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System, including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall develop an RFA that includes, at a minimum, the elements described in this rule~~.~~:

(a) This rule lists legal requirements for CCOs, followed by corresponding application requirements that CCO applicants shall be required to address in the RFA~~.~~:

(b) The Authority shall interpret the qualifications and expectations for CCO contracting within the context of the laws establishing health system transformation, as well as the Oregon Health Policy Board's adopted reports and policies~~.~~:

(c) ~~the~~The Authority's evaluation of CCO applications shall account for the developmental nature of the CCO system~~.~~:

(A) The Authority recognizes that CCOs and partner organizations need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System~~.~~:

(B) An applicant who does not yet satisfy an RFA criterion must, at a minimum, have plans in place to meet the criterion. Unless otherwise specified in law or in the RFA, the Authority may use discretion in assessing whether the applicant is likely to make sufficient progress in implementing those plans to merit selection as a CCO candidate. Depending on the applicant's level of readiness, the Authority may consider invoking its authority under OAR 410-141-3700(4)(f) to deem an applicant "potentially eligible~~.~~:"

(C) Contract provisions, including an approved Transformation and Quality Strategy (TQS) and work plan for implementing health services transformation, shall describe how the CCO will comply with transformation requirements under these rules throughout the term of the CCO contract to maintain compliance.

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

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

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

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

(c) Operating within a fixed global budget;

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

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

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

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

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

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

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

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

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

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

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

(6) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3730.

~~(7) Dental care organizations: Each CCO shall have a contractual relationship with any DCO in its service area.~~

~~(8~~

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

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

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

(~~9~~8) CCOs shall provide integrated, person-centered care and services designed to provide choice, independence, and dignity. The applicant shall describe its strategy:

(a) To assure that each member receives integrated, person-centered care and services designed to provide choice, independence, and dignity;

(b) For providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.

(~~10~~9) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to certified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall describe:

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

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

(~~11~~10) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:

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

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

(~~12~~11) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:

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

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

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

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

(e) Include providers of specialty care;

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

(g) Establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in alignment with contractual requirements;

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

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

(~~13~~12) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(~~14~~13) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

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

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

(~~15~~14) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting to include warm handoffs as appropriate based on requirements in OAR 309-032-0860 through 0870. Applicants shall:

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

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

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

(~~16~~15) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, and Traditional Health Workers (THW). THWs include~~,~~:

(a) Peer wellness specialists;

(b) Peer-support specialists;

(c) Personal health navigators;

(d) Family support specialist;

(e) Youth support specialist;

(f) Doulas; and

(g) Community health workers navigators.

(~~17~~16) The applicant shall describe its planned policies for informing members about access to all types of THWs identified in OAR 410-180-0305.

(~~18~~17) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

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

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

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

(~~19~~18) CCOs shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with serious and persistent mental illness covered under the state's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:

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

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

(~~20~~19) CCOs shall participate in the learning collaborative described in ORS 413.259. Applicants shall confirm their intent to participate.

(~~21~~20) CCOs shall implement to the maximum extent feasible patient-centered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations~~.~~:

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

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

(~~22~~21) CCOs' health care services shall be culturally and linguistically appropriate and focus on achieving health equity and eliminating health disparities. The applicant shall describe its strategy for:

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

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

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

(~~23~~22) CCOs are required to use alternative payment methodologies consistent with ORS 414.653. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0125 and 409-025-0130. The applicant shall describe its plan to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.

(~~24~~23) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

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

(b) Its plan to support increased rates of electronic health record adoption among contracted providers, and to ensure that providers have access to health information exchange for care coordination;

(c) Its plan to use HIT to make use of hospital event notifications and to administer value-based payment initiatives.

(~~25~~24) CCOs shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the APAC data reporting system, and follow expectations for participation in annual TQS reporting to the Authority as detailed in the contract and external quality review with the Authority contracted External Quality Review Organization as outlined in 42 CFR §§ 438.350, 438.358, and 438.364. The applicant shall provide assurances that:

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

(b) It submits, or it will submit, APAC data in a timely manner pursuant to OAR 409-025-0130.

(~~26~~25) CCOs shall be transparent in reporting progress and outcomes. The applicant shall:

(a) Describe how it assures transparency in governance;

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

(~~27~~26) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:

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

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

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

(~~28~~27) CCOs shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations~~.~~:

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

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

(~~29~~28) CCOs may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.

(~~30~~29) CCOs shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

410-141-3710 Contract Termination and Close-Out Requirements

(1) This rule applies to any termination of an MCE contract, including but not limited to non-renewal under OAR 410-141-3725, expiration of the contract at the end of its term, or termination during the term of the contract initiated by either party. Consistent with OAR 410-141-3725, MCEs shall abide by all requirements in this rule regardless of whether termination notice is provided by the Authority or the MCE.

(2) The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery and a contemporaneous copy emailed to the other party's contract administrator.

(3) The notice of termination shall specify the circumstances giving rise to termination and the date on which such termination shall become effective.

(4) After receipt of an MCE's notification of intent not to renew or notice of termination, the Authority shall issue written notice to the MCE specifying:

(a) The effective date of termination;

(b) The MCE's operational and reporting requirements; and

(c) Timelines for submission of deliverables.

(5) Upon notification of termination or non-renewal, an MCE shall submit to the Authority a transition plan detailing how it fulfills its continuing obligations for the duration of the contract. The transition plan shall include:

(a) How each of the MCE's members and contracted providers are notified of the termination of the contract;

(b) A plan to transition its members to other MCEs; and

(c) A plan for closing out its MCE business, including but not limited to the operational and reporting requirements and timelines for submission of deliverables, as specified by the Authority, and the requirements specified in this rule.

(6) Transition plans are subject to approval by the Authority:

(a) The MCE must revise the transition plan as necessary to obtain approval by the Authority;

(b) Failure to submit a transition plan and obtain written approval of the termination plan by the Authority may result in the Authority's withholding of 20 percent of the MCE's monthly capitation payment until the Authority has approved the transition plan;

(c) If the Authority's approval of the transition plan occurs less than 90 days before the effective date of termination, then the Authority may require the MCE to extend the contract to a later effective date of termination, including as necessary the MCE's acceptance of amendments to the contract generally applicable to MCE contracts through the extended effective date.

(7) The MCE shall designate an individual as the contract transition coordinator.

(8) The contract transition coordinator shall be the Authority's contact for ensuring the MCE's completion of the MCE's contractual obligations, performance, operations, and member transitions including the transition plan.

(9) MCEs must submit reports to the Authority every 30 calendar days detailing the MCE's progress in executing its transition plan. In the event of the MCE's substantial failure to execute timely its transition plan, the Authority may withhold 20 percent of any payments due to the MCE from the Authority until such failure is corrected.

(10) MCEs shall submit a final report to the Authority describing how it fulfilled all transition and close-out activities described in the transition plan. The final report is subject to the Authority approval before issuance of any final payment.

(11) MCEs shall continue to perform all financial, management, and administrative services obligations identified in contract throughout the closeout period, including at minimum:

(a) Restricted reserves and insurance coverage for a period of 18 months following the notice of termination, or until the state provides the MCE with written release agreeing that all continuing obligations are fulfilled, whichever is earlier;

(b) Maintaining adequate staffing to perform all required functions as specified in contract;

(c) Supplying all information necessary to the Authority or its designee upon request for reimbursement of any outstanding claims at the time of termination;

(d) Assisting the Authority to ensure an orderly transition of member services after notice of termination consistent with the Authority's Transition of Care Policy; and

(e) To make available all signed provider agreements or subcontracts to the Authority upon request.

(12) The MCE must arrange for the orderly transfer of all OHP members assigned to the MCE to coverage under any new arrangement authorized by the Authority, including any actions required by the Authority to complete the transition of members and the termination of the MCE contract. These actions include:

(a) Forwarding of all medical or financial records related to the contractually obligated activities;

(b) High needs care coordination;

(c) Facilitation and scheduling of medically necessary appointments for care and services;

(d) Identification of chronically ill high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.

(13) If a change of providers may be harmful to the member, the MCE must continue to provide services until that treatment is concluded or appropriate transfer of care is arranged.

(14) The MCE shall make available and require its providers and subcontractors to make available to the Authority copies of medical, behavioral, oral and managed long-term services and supports records, patient files, and any other pertinent information necessary for efficient care management of enrollees, as determined by the Director of the Authority:

(a) Records shall be in a usable form and shall be provided at no expense to the Authority, using a file format and dates for transfer specified by the Authority;

(b) Under no circumstances shall a Medicaid member be billed for this service;

(c) Information that shall be required includes:

(A) Numbers and status of grievances in process;

(B) Numbers and status of hospital authorizations in process, listed by hospital;

(C) Daily hospital logs;

(D) Prior authorizations approved, pending, or denied;

(E) Program exceptions approved;

(F) Medical cost ratio data;

(G) Information on outstanding payments for medical care rendered to members;

(H) All encounter data required under the terminated agreement;

(I) Identification of members whose treatment or treatment plans require continuity of care consideration;

(J) Any other information or records deemed necessary by the Authority to facilitate the transition of care.

(15) Following expiration of the contract and the completion of closeout period obligations, the MCE shall:

(a) Maintain claims processing functions as necessary for a minimum of 18 months after the date of termination. If additional claims are outstanding, the MCE shall maintain the claims processing system as long as necessary to complete final adjudication of all claims;

(b) Remain liable and retain financial responsibility for all claims with dates of service prior to the date of termination;

(c) Maintain financial responsibility for patients who are hospitalized prior to the termination date through the date of discharge or for patients receiving post hospital extended care benefits after termination to the extent the MCE is responsible under the contract;

(d) Maintain financial responsibility for services rendered prior to the termination date, for which payment is denied by the MCE and subsequently approved upon appeal by the provider; and

(e) Assist the Authority with grievances and appeals for dates of service prior to the termination date.

(16) Runout activities shall consist of the processing, payment, and reconciliations necessary regarding all enrollees, claims for payment from providers, appeals by both providers and members, and financial reporting deemed necessary by the Authority, including:

(a) Monthly claims aging report including IBNR amounts;

(b) Quarterly financial statements and annual audited financial statements in conformity with the specification in the contract up to the date specified by the Authority;

(c) Certified encounter reporting until all services rendered prior to contract expiration or termination have reached adjudicated status and the Authority data validation of the information is complete;

(d) Arranging for the retention, preservation, and availability of all records, including those records related to member grievance and appeals, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement, and those records covered under HIPAA as required by contract and state and federal law;

(e) Details of any existing third-party liability (TPL) or personal injury lien (PIL) cases and making any necessary arrangements to transfer the cases to the Authority's TPL and PIL units; and

(f) Final reports that identify all expenditures for any period in which the MCE continued to pay claims for services provided during the contract period.

(17) The Authority may require status reports or updates to the data reporting requirements in section (16) upon request.

(18) MCEs shall submit to the Authority a written request for release certifying that all obligations have been satisfied. The Authority shall provide an official written release upon satisfaction of activities associated with the contract expiration or termination plan. The request must be signed, expressly under penalty of False Claims Act liability, by the president and the chief financial officer of the MCE and must attest that, except as expressly described in a writing attached to the attestation:

(a) All payments are received by the MCE under the contract, and all the MCE's liabilities under the contract are extinguished;

(b) All reports, reconciliations, member matters, and provider matters are resolved and finalized; and

(c) The MCE complied with all contractual and legal requirements, including completion of the activities described in the transition plan.

(19) To the extent that the request for release under section (18) attaches any exception, the request for release must include a plan describing how each exception is resolved. Any payments due under the terms of the contract for services between the Authority and the MCE, including the distribution of restricted reserve funds or any withheld capitation amount, may be withheld until the Authority receives all written and properly executed documents from the MCE. The MCE is subject to all obligations under the contract, associated rules, and the transition plan until a final written release is issued by the Director of the Authority. Such release:

(a) Shall apply only to the extent of the MCE's responsibilities under the MCE contract, associated rules, and the transition plan;

(b) Shall apply only to the extent the MCE's submissions to the Authority are true, complete, and accurate;

(c) Shall apply only between the Authority and the MCE;

(d) May not bind third parties;

(e) May not preclude the Authority's assertion of indemnity, contribution, or other obligations based on third-party claims;

(f) May not preclude the Authority's assertion of false claims liability, Medicaid fraud, common-law fraud, or other claims, false statements, or fraud; and

(g) May not affect any post-termination obligations of the MCE under the contract for preservation of records or for auditors' access.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3715 CCO Governance; Public Meetings and Transparency

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

~~(2)~~ (2) Consumer Representative means a person serving on a CAC who is currently or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian, or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

~~(3)~~ (3) Each CCO's governing body must include:

(a) At least one member representing persons that share in the financial risk of the organization;

(b) A representative of a dental care organization selected by the coordinated care organization;

(c) The major components of the health care delivery system;

(d) At least two health care providers in active practice, including:

(A) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

(B) A mental health or chemical dependency treatment provider~~;~~.

(e) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(f) At least two members of the CAC~~.~~:

(A) At least one of the CAC representatives on the CCO's governing body must be a current CAC Consumer Representative~~.~~;

~~(B) These CAC representatives must not have any current or former relationship with the CCO, financial or otherwise, except as a Consumer Representative as defined in this rule. Impermissible relationships include employment or contractor relationships, either for the representatives themselves or for immediate family members.~~

(B) Any CAC member serving on a CCO governing board must disclose any conflicts of interest;

(C) CAC members of the governing body shall have full voting rights.

(4) For purposes of the open meetings requirement in Section 2 of Enrolled 2018 HB 4018, 2018 Oregon Laws Chapter 49, "substantive decision" means a decision made by the governing board of a coordinated care organization (CCO) that relates to:

(a) Spending of public funds;

(b) The financial risk of the CCO;
(c) Provider network development and capacity; or

(d) The community advisory council, community health assessment, or community health improvement plan.

(5) Substantive decision does not require or include:

(a) Disclosure of trade secrets as defined in ORS 192.345;

(b) Confidential communications with a lawyer that are privileged under ORS 40.225;

(c) Information of a personal nature as described in ORS 192.355;

(d) Protected health information as defined in ORS 192.556;

(e) Names of Oregon Health Plan consumer members of a community advisory council who request to remain anonymous;

(f) Confidential human resource matters; or

(g) Provider credentialing, sanctioning, or termination.

(6) The term "substantive decision" excludes immaterial technical decisions.

Statutory/Other Authority: ORS 413.042, ORS 414.615 & ORS 414.625
Statutes/Other Implemented: Oregon laws 2018 Chapter 49

410-141-3720 Service Area Change for Existing CCOs

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

(a) "Applicant" means a coordinated care organization (CCO) as defined in ORS 414.625 with a CCO contract with the Authority that submits an application seeking a contract amendment for a new service area. The CCO is described for purposes of this rule as the applicant upon its submission of the CCO Letter of Intent to Apply;

(b) "Document Review" means the review conducted by the Authority, occurring at the point after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant's ability to serve Medicaid beneficiaries in the requested service areas;

(c) "Letter of intent to apply (LOIA)" means a letter from a CCO to the Authority stating the CCO's intent to submit a SAC packet in response to a service area need. A LOIA may be binding or non-binding, as specified in the Authority's announcement of the service area need;

(d) "SAC packet" means the packet of application documents that the Authority provides to CCOs applying for a SAC;

(e) "Service Area Change" or "SAC" means a change in a CCO's service area as specified in the Authority's contract with the CCO;

(f) "Service Area Need" means when the Authority identifies a need, as defined in section (3) of this rule, for existing CCOs to apply to the Authority for a SAC to serve a service area.

(2) A CCO that desires to withdraw from all or a portion of its service area shall make every effort to provide the Authority with a form Letter of Intent to Exit the service area at least 150 calendar days prior to the intended date of withdrawal. The template for this form can be found on the CCO Contract Forms page ~~at~~. The Authority shall work with the CCO and any other impacted CCO for a workable exit transition.

(3) The Authority may determine a service area need exists, or is anticipated to exist, when a CCO would no longer be serving all or a portion of its service area.

(4) The Authority shall follow the process set forth in this rule when announcing a need for a SAC:

(a) Within ~~thirty~~30 days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for the SAC. The announcement shall specify when the LOIA is due;

(b) Not later than ~~fifteen~~15 calendar days from the date of the Authority's notification in section (4)(a) above, the Authority shall issue a second announcement of the Authority's identification of a need for a SAC and when LOIAs are due;

(c) To be considered for a SAC, interested CCOs shall submit their LOIAs by the deadline indicated in the Authority's notice of a need for a SAC. CCOs shall designate a sole point of contact in their LOIA for this process. The Authority will not accept a LOIA or any subsequent SAC application materials from a CCO that has not submitted a LOIA by the deadline indicated in the Authority's notice;

(d) The Authority shall send a letter of acknowledgement to the CCO within ~~ten~~10 calendar days of receipt of the LOIA.

(5) Within ~~thirty~~30 calendar days of the date specified by the Authority as the due date for submission of a LOIA, the CCO shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC application packet. CCOs can locate a SAC packet on the CCO Contract Forms page.

(6) CCOs applying for the service area change process outlined in this rule must meet the requirements set forth in ORS 414.625 and submit documentation as it applies to the new service areas indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3700 and 410-141-3705, shall be included in the acknowledgement letter sent by the Authority as described in section 4(d), which shall include, but is not limited to, information related to the following:

(a) Delivery system network and provider capacity reports highlighting any providers operating in the new service area or existing contracted providers expanding their services into the new service area. This report would include providers of physical health, oral health, behavioral health, and non-emergent medical transportation. New relationships with dental care organizations (DCOs) and Non-Emergent Medical Transportation brokerages are to be included;

(b) Updated financial reports;

(c) Updated CCO governance organizational charts reflecting any changes due to new service area including CCO leadership and managerial staffing, changes to Community Advisory Committee members, Clinical Advisory Panels membership, and any other committee or governance structure change as a result of operating in the new service area;

(d) Letters of community support from the community or communities in the new service area in which the CCO is applying to operate;

(e) List of specific new zip codes the CCO intends to serve and the estimated enrollment for each zip code area;

(f) Memorandums of understanding or letters of intent to enter into memorandums of understanding with local APD/AAA agencies, local mental health authority, local public health authority, and any other key stakeholders represented in the new service area;

(g) Updated Community Health Improvement Plan (CHP) reflecting new service area goals, if applicable;

(h) Updated Transformation Plan benchmarks or focus areas reflecting new service area goals, if applicable;

(i) Information related to how services in the new service area will impact existing operations including updated policies and procedures as applicable;

(j) Information related to identifying regional, cultural, socioeconomic, and racial disparities in health care that exist among the enrollees in the new service area and establishing community support for those areas of need; and~~,~~

(k) Information related to coordination of care and transfer of new members, specifically high -risk members or members with special health care needs.

(7) The Authority shall review SAC packets from all CCOs that have timely submitted a LOIA and SAC packet as required by this rule and that are considered responsive and completed as set forth in this rule.

(8) During its review of the SAC packets, the Authority may request additional information from a CCO. If additional information is requested, the CCO shall submit the additional information to the Authority within 30 days of the request.

(9) Within ~~sixty~~60 calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information. To be eligible for recertification in the new service area, the applicant must meet standards established by the Authority, this rule, and be in compliance with the contract between the CCO and the Authority.

(10) The Authority shall determine which CCO(s) will be selected to serve the new service area under the procedures and criteria set forth in OAR 410-141-3700(4) and 3705.

(11) The Authority shall prepare a contract amendment for document review and signature to each CCO that receives approval to expand into the new service area. The CCO shall have ~~sixty~~60 calendar days to return an executed contract amendment for the service area change.

(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3550.

Statutory/Other Authority: ORS 413.042, 414.645 & 414.625
Statutes/Other Implemented: ORS 413.042

410-141-3725 CCO Contract Renewal Notification

(1) No later than 134 days prior to the end of a benefit period, the Authority shall provide each CCO with notice of the proposed changes to the terms and conditions of the contract for the next benefit period that the Authority submits to the Centers for Medicare and Medicaid Services for approval.

(2) If a CCO declines a contract renewal with the Authority, the CCO must notify the Authority of its intention not to enter into the contract renewal no later than 14 days after the Authority's notice of proposed changes as described in section (1).

(3) A CCO's notice to the Authority of intent not to enter into a contract renewal terminates the contract at the end of the benefit period unless:

(a) The Authority at its discretion requires the contract to remain in force into the next benefit period and be amended as proposed by the Authority until 90 days after the CCO has in accordance with criteria prescribed by the Authority:

(A) Notified each of its members and contracted providers of the termination of the contract;

(B) Provided to the Authority a plan to transition its members to other CCOs; and

(C) Provided to the Authority a plan for closing out its CCO business.

(b) The Authority may at its discretion waive compliance with the deadlines stated in sections (2) or (3) if the Authority determines such waiver to be consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

(4) A CCO that declines to renew its contract shall comply with the termination and close-out requirements in OAR 410-141-3710, except as otherwise provided in this rule.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651 & 414.652
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3730 Community Health Assessment and Community Health Improvement Plans
~~**(Revised 7/30/19)**~~

(1) CCOs shall comply with the requirements in ORS 414.627 and 414.629, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.

~~(2~~

(2) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.

(3) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:

~~(a)~~ (a) County and city government representatives;

~~(b)~~ (b) Federally recognized tribes (if not already collaborating on a shared CHA);

~~(c)~~ (c) SDOH-~~HE~~E partners, as defined in OAR 410-141-3735;

~~(d) Local public health authorities;~~

~~(e)~~ (d) Local mental health authorities and community mental health programs;

~~(f) Hospitals;~~

~~(g)~~ (e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

~~(h)~~ (g) Indian Health Care Providers;

~~(i)~~ (h) Traditional Health Workers;

~~(j)~~ (i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

~~(k)~~ (j) Culturally specific organizations, including Regional Health Equity Coalitions; and

~~(l)~~ (k) Representatives from populations who are experiencing health and health care disparities~~;~~.

(~~3~~4) The CHA must include or identify and ~~analyze,~~analyse at a minimum, all of the following:

(a) The demographics of all of the Communities with Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, gender, and sexual orientation;

(b) The health status and issues of all the Communities within Contractor's Service Area;

(c) The health disparities among all of the Communities within Contractor's Service Area;

(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;

(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);

(f) Assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:

~~(A)~~ (A) Access to primary prevention resources;

~~(B)~~ (B) Disproportionate, unmet, health-related needs;

~~(C)~~ (C) Description of assets within the Community that can be built on to improve the Community's health;

~~(D)~~ (D) Systems of seamless continuum of care; and

~~(E)~~ (F) Systems or programs of collaborative governance of community benefit.

(g) ~~Identify programs that~~Means to promote the health and early intervention in the treatment of children and adolescents within Contractor's Service Area, ~~including any treatment prevention and Early Intervention programs, and analyze the sufficiency and effectiveness of any such programs~~and whether they are sufficient and effective;

(h) ~~Identify areas~~Areas for improvement; and

(i) ~~Document the~~The persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.

~~(4) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.~~

(5) CCOs and their CACs must develop ~~meaningful~~ baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, ~~living setting~~neighborhood and environment, or other factors. This data will be used to identify and prioritize strategies to reduce health disparities in the development of their CHPs.

(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).

(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP ~~or shared CHP priorities and strategies~~. The CCOs' CACs are responsible for adopting CHPs.

(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:

~~(a)~~ (a) County and city government representatives;

(b) ~~(b)~~ Federally recognized tribes (if not already collaborating on a shared CHA);

~~(c)~~ (c) SDOH-~~HE~~E partners, as defined in OAR 410-141-3735;

~~(d) Local public health authority;~~

~~(e) Hospitals~~

~~(f)~~ (d) Local mental health authorities and community mental health programs;

~~(g)~~ (e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

~~(h)~~ (g) Indian Health Care Providers;

~~(i)~~ (h) Traditional Health Workers;

~~(m)~~ (i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

~~(j)~~ (j) Culturally specific organizations, including Regional Health Equity Coalitions; and

~~(k)~~ (k) Representatives from populations who are experiencing health and health care disparities.

(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.

~~(a)~~ (a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:

~~(A)~~ (A) Closing the gap on disproportionate, unmet, health-related needs;

~~(B)~~ (B) Creating access to primary prevention;

~~(C)~~ (C) Building a system of seamless continuum of care;
~~(D)~~ (D) Building on current Community resources and improving Community capacity to improve health or address SDOH~~/HE~~-E, or both; and

~~(E)~~ (E) Engaging the Community in the implementation of the CHP.

~~(b)~~ (b) The CHP strategies should be based on research and may include, without limitation:

~~(A)~~ (A) Developing a or supporting Health Policy that supports the CHP goals and objectives;

~~(B)~~ (B) Implementing or supporting community health or SDOH~~/HE~~-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

~~(C)~~ (C) Developing public and private resources and capacities;

~~(D)~~ (D) Designing and building a system of Integrated service delivery;

~~(E)~~ (E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.

(c) The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies~~.~~;

(d) The CHP must also ~~include a component for addressing the health of child and youth in the CCO service area. This must be developed~~address, with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the ~~Early Learning Council, Early Learning Hubs, the Youth Development council and the school health providers in the region. This component addressing the~~ needs of adolescents and children in a CCO's Service Area and must address:

~~(A) Include findings~~(A) Findings based on research, including adverse childhood experiences~~and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan~~;

~~(B) Evaluate the~~(B) The adequacy of existing school-based ~~resources including school based~~ health ~~centers~~center (SBHC) ~~to meet the specific pediatric and adolescent health care needs in the community;~~networks and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community~~, including the addition or improvement of electronic medical records and billing systems~~;~~.~~

~~(C) Take into consider whether integration of school based health centers with the larger health system or system of community clinics would further advance the goals of the plan;~~

(C) The integration of all services provided to meet the needs of children, adolescents, and families; and

~~(D)~~ (D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.

~~(10) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.~~

~~(11~~

(10) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and

improving health equity. Progress reports will be submitted in the manner and form proscribed by OHA.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3735 Social Determinants of Health and Equity; Health Equity

(1) This rule defines health disparities and ~~establishes requirements for~~ the social determinants of health and equity (SDOH-E)~~ spending programs~~, establishes requirements for the Supporting Health for All through Reinvestment Initiative (SHARE Initiative), establishes the role of the Community Advisory Councils in supporting SDOH-E, ~~and~~establishes requirements for collecting data on race, ethnicity, and primary language, and establishes requirements for developing health equity infrastructure within a Coordinated Care Organization (CCO). ~~The~~This rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.

(2) The following definitions apply for purposes of this rule:
~~(a) "Adjusted Net Income" is the pre-tax net income reported by a CCO for a calendar year (or a partial year, if relevant) pursuant to OAR [SB 1041 financial reporting rules under SAP], modified by the following items at the discretion of the Authority:~~
~~(A) Excessive administrative expenses, including management bonuses~~
~~(B) Improper allocation of expenses across lines of businesses~~
~~(C) Non-operating revenues and expenses~~
~~(D) Adjustments to base data made as part of the capitation rate development~~
~~(E) Other expenses not supported by legitimate business purposes~~
~~(F) Payments or transfers to subcontractors, parent companies, affiliates, or subsidiaries~~
~~(b~~

(a) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the ~~metric~~indicators used to ~~measure~~track progress toward achieving health equity.

(~~c~~b) "Social Determinants of Health and Equity" (SDOH-E)~~.~~:
~~(A~~

(A) SDOH-E encompasses three terms:

(i) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities~~. Social determinants of health fall into the following domains: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health.~~;

(~~B~~ii) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities~~.~~;
~~(d) "SDOH-E Partner" means a community-based entity that delivers services or programs, or supports policy and systems change, or both to address the social determinants of health and health equity; that the CCO has selected to receive a portion of the CCO's SDOH-E Spending.~~

(iii) Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.

(eB) "SDOH-E Spending" means spending on services and initiatives designed to address SDOH-E. SDOH-E spending may consist of spending on health-related services, as that term is defined in OAR 410-141-3845 and OAR 410-141-3500. SDOH-E programs may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:
(A) Population health policy change, meaning changes to rules or procedures within a community or organization;
(B) Systems change, meaning changes to infrastructure within a community or organization, and,
(C) Services

(i) Community-level interventions that directly address social determinants of health or social determinants of equity;

(ii) Interventions to address individual's health-related social needs, meaning an individual's social and economic barriers to health, such as housing instability or food insecurity.
(f) "SDOH-E Spending Program" means a program overseen by the Authority with specific requirements for a CCO's SDOHE Spending as set forth in the contract. SDOH-E spending programs include, but may not be limited to:
(A)

(3) The following definitions are specific to the Supporting Health for All through Reinvestment Initiative (SHARE Initiative)
(B) Boosting Up Investment in Long-term Development for SDOH-HE Fund (BUILD Fund)
(3:

(a) "Adjusted Net Income" is the pre-tax net income reported by a CCO for a calendar year (or a partial year, if relevant), modified by the following items at the discretion of the Authority:

(A) Excessive administrative expenses, including management bonuses;

(B) Improper allocation of expenses across lines of businesses;

(C) Non-operating revenues and expenses;

(D) Adjustments to base data made as part of the capitation rate development;

(E) Other expenses not supported by legitimate business purposes;

(F) Payments or transfers to subcontractors, parent companies, affiliates, or subsidiaries.

(b) "SDOH-E Partner:"

(A) A single organization, local government, one or more of the Federally-recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative;

(B) That delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area; and

(C) That the CCO has selected to receive a portion of the CCO's SDOH-E dollars.

(4) The following ~~general~~ requirements ~~apply~~are specific to ~~any SDOH-E spending program~~the Supporting Health for All through Reinvestment Initiative (SHARE Initiative):

(a) For each calendar year starting on or after January 1, 2021, CCOs shall dedicate a portion of their previous calendar year's adjusted net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018) and as set forth in the contract;

(~~a~~b) CCOs shall select SDOH-E spending priorities ~~based on~~that fall into at least one of four domains of SDOH-E: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health, and are consistent with:

(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs~~.~~; and

(B) Any SDOH-E priority areas identified by the Authority~~.~~:

(~~b~~i) A portion of ~~SDOH-E Spending Program expenditures~~SHARE Initiative dollars must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract, or a Memorandum of Understanding, with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO. ~~These contracts shall be submitted to the Authority for.~~

(c) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.

~~(4) The following requirements are specific to the SHARE Initiative:~~

~~(a) For each calendar year starting on or after January 1, 2021, CCOs shall dedicate a portion of their previous calendar year's adjusted net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018) and as set forth in the contract.~~

~~(b) The portion of adjusted net income or reserves spent, as referenced above, shall equal or exceed the greater of:~~

~~(A) % of adjusted net income for the prior calendar year on a sliding scale based on Contractor's % Risk Based Capital (RBC) as of the end of that year (but prior to the SHARE portion calculation); or~~

~~(B) A proportion of the amount sent in dividends or payments or both to shareholders, parents, or other owners in that prior year.~~

~~(c) The Authority will provide the specifications for (A) and (B), including the sliding scale, as an initial reference document to CCOs by October 1, 2019, and publish any revisions for subsequent years by October 1st preceding a calendar year affected by such revision.~~

~~(d) The value of the %RBC floor, for the purposes of the sliding scale, will be the greater of:~~

~~(A) 250% RBC, or~~

~~(B) the percentage established in rule development for SB 1041 in relation to dividend payment restrictions.~~

~~(e) The Authority's discretion in adjusting net income shall be for the purpose of ensuring that CCOs do not distribute net income to stakeholders through other means than dividends (or similar payments to owners) to avoid SHARE Initiative spending. The Authority's discretion may also extend to relief from SHARE Initiative requirements in the event of net losses outside the CCO's reasonable control that would otherwise place the CCO's capital, surplus or reserves below 200% RBC.~~

~~(5) The following requirements are specific to the BUILD Fund:~~

~~(a) Dependent on availability of funds under the Medicaid growth cap, and within the Authority's budget at the discretion of its Director, the Authority may require that CCOs spend a fixed portion of their income on SDOH-E, in compliance with all SDOH-E Spending Program rules as set forth in this OAR, in the Contract between the CCO and the Authority, and in related guidance documents.~~

~~(6~~

(5) Community Advisory Councils (CAC)~~:~~:

(a) CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on SDOH-E, including the ~~SDOH-E Spending Programs~~SHARE Initiative, and health-related services community benefit initiatives, as defined in OAR 410-141-3845. ~~Interested~~CCOs shall have a conflict of interest policy that applies to its CAC members~~—~~ and accounts for ~~example, a member whose employer is up for consideration as an SDOH-E partner—shall recuse themselves from the decision-making process.~~financial interests related to potential SDOH-E spending;

(b) CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues~~, as well as~~. These reports shall also detail the CCO's efforts to ~~align~~ensure the CAC's composition ~~with~~is representative of the communities in the

CCO ~~membership~~'s ~~demographic composition~~service area, and in alignment with its CHP priorities. CCOs should consider which populations in their communities should be represented on their CAC(s). These reports will be posted publicly with appropriate redactions.

~~(8~~

(6) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.

(7) Health Equity Infrastructure~~.~~:

(a) The term "Health equity infrastructure" refers to the adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality language access; workforce diversity; ADA compliance and accessibility of CCO and provider network; ACA 1557 compliance; CCO and provider network organizational training and development; implementation of the CLAS Standards; non-discrimination policies;

(b) The "Health Equity Plan" is part of the "Health Equity Infrastructure;"

(~~a~~c) CCOs shall develop and implement ~~a~~the "Health Equity Plan" to ~~address~~embed health ~~disparities that exist among the CCOs' members and, more generally, the communities within the CCOs' service areas~~equity as a value and business practice into organizational policies, procedures, and processes; meet state and federal laws and contractual obligations regarding accessibility and culturally and linguistically responsive health care and services; inform using an equity framework in all policy, operational, and budget decisions; provide a structure to ensure oversight and management of programs and services with the goal to advance health equity and provide culturally and linguistically appropriate services. The health equity plan shall include the following:

(A) Narrative of the health equity plan development process, including description of meaningful community engagement~~.~~;

(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics~~.~~;

~~(C) A plan for ensuring that the CCO's staff and provider network are trained on~~

(C) Organizational and Provider Network Cultural Responsiveness and Implicit Bias training plan:

(i) CCO shall incorporate Cultural Responsiveness and implicit bias continuing education and training into its existing organization-wide training plan and programs;

(ii) CCO shall align cultural responsiveness~~,~~ and implicit bias~~, and anti-discrimination laws, in accordance with the Authority's standards~~ trainings with the "Cultural Competence Continuing Education" criteria developed by the Authority's Cultural Competence Continuing Education Advisory Committee referenced in OAR 943-090-0020;

(iii) CCO shall adopt the definition of Cultural Competence set forth in OAR 943-090-0010;

(iv) CCO shall provide and require all its employees, including directors, executives, and CAC members to participate in all such trainings;

(v) CCO's shall require all of the CCO's Provider Network to comply with Cultural Competency Continuing Education requirements set forth in ORS 676.850.

(~~b~~d) The health equity plan and the language access self-assessment report are required to be submitted under OAR 410-141-3515 and shall be submitted every year to the Authority for review and approval~~.~~;

(~~c~~e) CCOs shall designate a Single Point of Accountability. The single point of accountability ~~for health equity with~~can also be called the Health Equity Administrator:

(A) The Single Point of Accountability ("Health Equity Administrator") shall be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network and CCO service area;

(B) The Single Point of Accountability ("Health Equity Administrator") shall have budgetary decision- making authority and health equity expertise.;

(C) The Single Point of Accountability ("Health Equity Administrator") shall be a high-level employee (e.g., director level or above) and can have more than one area of responsibility and job title;

(D) The CCO shall inform and describe to the authority any changes related to the "Health Equity Administrator" role or scope using the Health Equity Plan;

(E) The Single Point of Accountability ("Health Equity Administrator") shall have the authority to communicate directly with CCO executives and governing board.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3740 Traditional Health Workers

(1) The Authority ~~seeks to ensure~~requires that all CCO members based on their health needs must have access to certified traditional health workers (THWs) who are part of the member's care team ~~to improve~~in clinical and community-based settings to ensure members have improved access to appropriate services ~~and~~. The THWs, as a part of the member's care team, must participate in processes affecting the member's care and ~~services. THW is defined in OAR 410-180-0305~~service needs. THW is defined in OAR 410-180-0305.

(2) CCOs shall develop and implement a plan for integrating and utilizing THWs, in accordance with this rule and the CCO contract~~.~~:

(a) THW integration and utilization plans shall include:

(A) Information on THW access and usage for CCO members;

~~(B) Measurement standards and benchmarks;~~
(B) Benchmarks and measurement of baseline data for integration and utilization of THWs;

(C) Evaluations of the CCO's progress in reaching those benchmarks~~; and~~.

(b) THW integration and utilization plans shall be submitted to OHA as required under the contract.

(3) CCOs shall establish, based on ~~recommendations~~OHA's and ~~standards issued by~~ the Traditional Health Worker Commission guidelines, a THW payment ~~model~~ grid that ~~defines~~includes alternative and sustainable ~~THW payment levels and alternative~~ payment strategies. ~~The~~Each CCO shall ~~make this payment model grid~~provide its THW Payment Grid to OHA. OHA will then post each CCOs Payment Grid to make them publicly available.

(4) CCOs shall designate a THW liaison, who shall serve as the central point of contact for THW integration.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3800 CCO Enrollment for Children Receiving Health Services

(1) Pursuant to OAR 410-141-~~38050~~3805, the Authority or Oregon Youth Authority (OYA) shall select CCOs for a child receiving services in an area where a CCO is available. If a CCO is not available in an area, the Authority shall, to the extent feasible, enroll the child in an MHO in accordance with the procedures described in this rule; in such an event, the MHO is subject to the requirements described in this rule for CCOs.

(~~1~~2) The Authority shall to the maximum extent possible ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority unless the Authority authorizes disenrollment from a CCO~~.~~:

(a) Except as provided in OAR 410-141-3805 (Coordinated Care Enrollment Requirements), 410-141-3810 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO or DCO on the basis of third-party resources (TPR) coverage consistent with OAR 410-141-3805~~.~~:

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

(~~2~~3) When a child is transferred from one CCO to another CCO or from FFS to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3860~~.~~:

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

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

(~~3~~4) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area~~.~~:

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

(b) Children receiving ~~CAF~~children, adult, and family services ~~enroll~~from the Department who are eligible to be enrolled with the CCO serving the geographic area of placement~~. Child Welfare~~: Department representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary~~.~~:

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

(~~4~~5) If the Authority enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall coordinate care and pay for covered health services during that placement even if the location of the facility is outside the CCO's service area~~.~~:

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

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

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

(~~5~~6) Except for OAR 410-141-3805 and 410-141-~~3080~~3810, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3805 Mandatory MCE ~~Enrolment~~Enrollment Exceptions

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

(a) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;

(b) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(c) "Renewal," means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) CCO enrollment is mandatory in all areas served by a CCO. A client eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.

(3) MCE enrollment is mandatory in~~-~~ service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:

(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or

(b) The member shall be enrolled with a CCO for physical health and behavioral health services and with a DCO for oral health services; or

(c) The member shall be enrolled with a CCO for behavioral health and oral health services and shall remain FFS for physical health services; or

(d) The member shall be enrolled with a CCO for behavioral health services and with a DCO for oral health services and shall remain FFS for physical health services; or

(e) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services and shall remain FFS for physical health services; or

(f) The member shall be enrolled with a DCO for oral health services and remain FFS for physical health and behavioral health services; or

(g) The member shall remain FFS for health care services if no MCE is available.

(4) MCE enrollment is voluntary in~~-~~ service areas without adequate access and capacity to provide health care services through an MCE.

(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.

(6) Members who are exempt from physical health services shall receive behavioral health services and oral health services through an MCE~~.~~:

(a) The member shall be enrolled with a CCO that offers behavioral health and oral health services; or

(b) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services; or

(c) The member shall be enrolled with a DCO for oral health services and shall remain FFS for behavioral health services if an MHO is not available; or

(d) The member shall remain FFS for both behavioral health and oral health services if neither a DCO nor an MHO is available.

(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:

(a) A newborn's services shall begin on the date of birth if the mother was a member of a CCO at the time of birth;

(b) For individuals other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;

(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

(~~8~~9) Pursuant to ORS 414.631, the following populations may not be enrolled into an MCE for any type of health care coverage:

(a) Individuals who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients with Medicare receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without another Medicaid;

(c) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).

(~~9~~10) In addition, the following enrollment rules apply:

(a) A newly eligible OHP client who became eligible while admitted as an inpatient in a hospital, or while receiving post-hospital extended care (PHEC), is exempt from enrollment with a CCO for physical health services but not exempt from MCE enrollment oral health services with a DCO. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client, or until the member completes PHEC or the PHEC benefit is exhausted;

(b) A client may not be enrolled in an MCE if the client is covered under a major medical insurance policy or other third-party resource (TPR) that covers the cost of services to be provided by an MCE as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800. A client shall, however, be enrolled with a DCO for oral health services even if they have a dental TPR.

(~~10~~11) Individuals who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from mandatory enrollment into an MCE, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(~~11~~12) A child in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area unless:

(a) Access to health care on an FFS basis is not available; or

(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.

(~~12~~13) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:

(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid~~.~~;

(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region~~.~~;

(c) A Medicare and full Medicaid dually eligible member may request to opt out of enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:

(A) Access to health care on an FFS basis is not available; or

(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;

~~(i)~~ (i) The development of a prior-authorized treatment plan;

~~(ii)~~ (ii) Care management requirements based on the beneficiary's medical condition;

(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and

(iv) Need for individual case conferences to ensure a "warm hand-off."

(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:

(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;

(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;

(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.

(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity.:

(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.

(1314) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis.:

(b) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area.
(C) Otherare not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care include the following:

(A) Enrollment poses a serious health risk; and
(B) The Authority finds no reasonable alternatives.

(1415) MCE enrollment standards.:

(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:

(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;

(B) Closed enrollment as a sanction for MCE misconduct.

(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;

(c) MCEs may confirm the enrollment status of a client by one of the following:

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

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

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

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

(~~e~~d) MCEs shall have open enrollment for 30 continuous calendar days during each ~~twelve~~12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.

(~~15~~16) If the Authority permits an MCE ~~is assumed by~~to assign its contract to another MCE, members shall be automatically enrolled in the ~~succeeding~~ MCE~~.~~ that has assumed the contract:

(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the ~~succeeding~~ MCE~~.~~ that has assumed the contract;

(b) If the ~~succeeding~~ MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.

(~~16~~17) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area and necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:

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

(b) ~~If~~The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority ~~must~~shall instead notify members of a change in participating providers or MCEs~~,~~. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. ~~The MCE shall provide members with at least a 30-calendar-day notice of such changes.~~

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3810 Disenrollment from MCEs

(1) Member-initiated requests for disenrollment.

(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule.

(b) ~~In accordance with 42 CFR 438.56(c)(2), the~~The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:

(A) Without cause ~~(applies to MAGI and non-Medicare APD members as defined by the Office of Client and Community Services Medical Programs OAR chapter 410 division 200).~~:

(i) Members may request to change their MCE enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle.

(ii) Members may request to change their MCE enrollment within 90 calendar days of the initial MCE enrollment. If approved, the change would occur during the next weekly enrollment cycle.

(iii) Members may request to change their MCE enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month.

(iv) Members may request to change their MCE enrollment ~~during~~at their OHP eligibility renewal~~, as defined in OAR 410-141-3805. The OHP eligibility period is typically 12 months~~. If approved, the change would occur at the end of the month.

(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. ~~The plan change shall be considered "recipient choice."~~ If a request for disenrollment is approved under this section, the change would occur at the end of the month. ~~Once the recipient choice option has been applied, the member must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.~~

(~~c~~B) With cause, at any time~~, if any of the following situations apply.~~ as follows:

(i) The member moves out of the MCE service area; or

(~~A~~ii) Due to moral or religious objections~~,~~ the ~~MCE~~CCO does not cover the service the member seeks.

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

(~~C~~D) Members who disenroll from a Medicare Advantage plan shall also be disenrolled from the corresponding ~~MCE~~CCO. ~~The effective date of disenrollment shall be the first of the month that the member's Medicare Advantage plan disenrollment is effective.~~

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

(i) The member ~~moves out of the MCE service area;~~
~~(ii) The member~~ is a Native American or Alaskan Native with ~~Proof~~proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(~~ii~~iii) ~~Continuity of care that is not in conflict with any section of OAR 410-141-3805, or as defined in this rule~~The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. ~~Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider.~~ A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of ~~an OHP~~a member for a provider of a treatment, service, or supply~~, including but not limited to a decision of a provider to participate or decline to participate in a MCE or a decision by the MCE to decline to contract with a provider;~~.

~~(d) Temporary enrolment~~

(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary CCO exemption.

(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the member's administrative hearing rights; and

(F) If 30 calendar days pass without a decision from the Authority on a member's disenrollment request, the request becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).

(c) A member may request a temporary enrollment exception during pregnancy. as follows:

(A) A temporary ~~enrolment~~enrollment request will be granted if~~, as supported in 42 CFR 438.56(d)(2),~~ a member is at any point in the third trimester of pregnancy and:

(i) The member is newly determined eligible for OHP; or

(ii) The member is newly re-determined eligible for OHP and not enrolled in a ~~MCE~~CCO within the past three months; or

(iii) The member is enrolled with a new CCO MCE that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider.

(B) The enrollment exemption shall remain in place until 60 calendar days postdate of either the delivery of the member's child or the pregnancy otherwise ends, at which time the member shall ~~select and~~ be enrolled in the appropriate ~~MCE plan~~CCO in their service area. Where there is a choice among multiple CCOs in the member's service area they may choose an open plan; however, if the member does not express a preference to OHP, OHP will auto assign on a next weekly basis.

(~~e~~d) ~~Member~~Upon approval of a member's disenrollment ~~requests under this subsection (2) are subject to the following requirements.~~

~~(A) The member~~from a CCO, the Member shall join another ~~MCE~~CCO unless ~~the~~:

(A) The member resides in a service area where enrollment is voluntary~~,~~; or ~~the~~

(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805~~,~~; or ~~the~~

(C) The member meets disenrollment criteria stated in ~~42 CFR 438.56(c)(2), or there~~this rule; or

(D) There is not another ~~MCE~~CCO available and open to new enrollment in the service area.

~~(B) If 30 days pass without a decision from the Authority on a member's disenrollment request, the request becomes effective on the first day of the following calendar month (unless the Authority takes action before that date).~~

(2) MCE-initiated disenrollment requests.

~~(a) Subject to applicable disability discrimination laws and subsection (4), the Authority may disenroll members for cause upon request by the MCE. Routine disenrollment for cause includes, but is not limited to, the following scenarios:~~

~~(A) The member commits~~

(a) MCEs may request disenrollment for any of the reasons set forth below in this subsection (a). Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified in this subsection (a) below. After review of all necessary documentation submitted with an MCE's request, the Authority will grant such requests, except the Authority may deny requests based on the reason set forth in subparagraph (G) below.

(A) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization and the post-hospital extended care (PHEC) benefit. If the member is enrolled after the first calendar day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services, unless the member is a newborn child born to an OHP eligible mother enrolled with a CCO;

(B) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The CCO shall receive an emailed tracking number following the online report. The CCO may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO effective at the end of the month the TPL is reported. In some situations, the Authority may approve retroactive disenrollment;

(C) If a member has been residing outside the MCE's service area for more than three months unless previously arranged with the MCE. The MCE shall provide written documentation that the member has been residing outside its service area for more than three months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR will notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;

(D) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;

(E) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the

Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution; or

(F) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the MCE.

(G) The member had End Stage Renal Disease at the time of enrollment in the MCE.

(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.

(a) MCEs have the right to request the Authority disenroll members when they commit fraudulent or illegal acts related to ~~the member's~~ participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts.

(b) The MCE shall report any illegal acts to law enforcement authorities and, if appropriate, to the DHS Fraud Investigations Unit~~, consistent with 42 CFR 455.13~~.

(~~B) The member is uncooperative or disruptive, except where this is a result of the Member's special needs or disability.~~

~~(b) Routine~~c) When requesting disenrollment ~~for reasons other than an uncooperative or disruptive member shall comply with the requirements of this subsection (b).~~

~~(A) The MCO~~based on a member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the ~~Coordinated Account Representative (CAR). The~~Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, ~~and document that attempts at intervention were made as described below~~including any verification of reports submitted to law enforcement and, if applicable, the DHS Fraud Investigations Unit.

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

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

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

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

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

~~(c) The MCE shall submit any additional information or assessments requested by the Authority CAR.~~

~~(d) The Authority shall notify the member in writing of any approved routine disenrollment.~~

~~(e) Routine disenrollment for an uncooperative or disruptive member shall comply with the requirements of both subsection (b) and this subsection (c), unless the exception for expedited disenrollment applies as described below in subsection (d). If a member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence as the result of their special needs or disability, the MCE shall document each of the following:~~

(d) Based on the evidence presented, the CCO AR will review the disenrollment request and all submitted evidence with Authority staff. The review process will be documented and a recommendation for disenrollment will be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.

(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.

(a) Subject to applicable disability discrimination laws and this subsection (4), the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule.

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

~~(B) A MCE-staffed~~

(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:

(A) Physical, intellectual, developmental, or mental disability; or

(B) An adverse change in the member's health; or

(C) Under or over-utilization of services; or

(D) Filing a grievance or exercising any appeal or contested case hearing rights; or

(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or

(F) Uncooperative or disruptive behavior resulting from the member's special needs.

(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member. The provider shall document the written notification to the MCE in the member's medical record.

(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:

(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider. The MCE shall document the education, training, and the resources or services furnished to the reporting provider.

(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:

(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;

(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and

(iii) Inform the member that their continued behavior may result in disenrollment from the MCE.

(C) In the event the interventions undertaken in accordance with Subsections (e)(B) of this rule do not ameliorate the member's uncooperative or disruptive behavior, the MCE shall Contact the member's care team, or develop a member focused care team if one does not already exist, to support the member in remediating their behavior. If needed, and with the consent of the member, the care team shall involve other appropriate individuals working with the member in the resolution within the laws governing confidentiality. The MCE shall facilitate cross functional care conferences that include the member, member focused care team, and other individuals chosen by the member with appropriate releases documented.

(D) In the event the member's uncooperative or disruptive behavior continues after undertaking the efforts identified in subsections (e)(C) of this rule, the MCE shall convene an interdisciplinary team ~~review~~ that includes a mental health professional or behavioral specialist and other health care professionals who have the ~~appropriate~~ clinical expertise ~~in treating~~necessary for reviewing and assessing the member's ~~condition to assess the~~ behavior, ~~the~~their behavioral history, and previous ~~history of~~ efforts undertaken to manage the member's behavior~~;~~

~~(C) If warranted, a clinical assessment of whether the~~, including those developed through the members care team and care conferences, in order to determine whether the member may be able to remediate their uncooperative or disruptive behavior ~~will respond to~~through other reasonable clinical or social interventions~~;~~.

~~(D) Documentation of any~~

(f) All efforts undertaken in connection with this section (4) of the rule, including, without limitation, all interventions, written and oral communications, training and education provided to the member and the member's provider(s), as well as those persons who participated in any and all interventions, care teams, assessments and the like, shall be documented in the member's MCE case file and as applicable, the provider shall document all efforts undertaken in the member's medical record.

(g) If, after undertaking all efforts identified in subsection (e) of this rule, the member's disruptive or uncooperative behavior cannot be managed sufficiently in order for a provider to provide the services the member requires, the MCE may submit to its CCO AR on MCE letterhead a written request for disenrollment that complies with all of the following:

(A) Sets forth the reasons for the request for disenrollment, details the attempts at intervention and accommodations that ~~have been attempted and why the~~were made, why those interventions and accommodations ~~haven't worked;~~were not effective, and includes all written documentation required under subsection (f) of section (4) of this rule.

~~(E) Documentation of~~

(B) Identifies, and provides documentation in support of the identification of, any special health care needs or disability the disruptive or uncooperative member may have and describes:

(i) The relationship the uncooperative or disruptive behavior may have, if any, to the member's special health care needs or disability, which must be substantiated by a provider with the appropriate credentials and expertise in the member's special health care needs or disability; and

(ii) Why the MCE has concluded the member's disruptive or uncooperative behavior is not a consequence of the member's special health care needs or disability.

(C) States whether the member's uncooperative or disruptive behavior poses a direct threat to the health or safety of others.

(D) Identifies the documentation that supports the MCE's rationale for concluding that the member's continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either ~~this particular~~the member ~~or~~who has engaged in the uncooperative or disruptive behavior or the MCE's other members~~;~~.

~~(F~~

(E) Provide written documentation of CMS' approval for disenrollment of the member when the member is also enrolled in the CCO's Medicare Advantage plan.

(F) Furnish all other information and documentation requested by the MCE's CCO AR.

(h) If a Primary Care Provider (PCP) terminates the provider/patient relationship during the period of time the CCO is undertaking the efforts described in this section (4), the ~~MCE~~CCO shall, prior to submitting a request for disenrollment, attempt to locate another participating PCP ~~on their panel~~ who ~~shall~~will accept the member as their patient. If needed, the ~~MCE~~CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new ~~provider~~PCP to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be consistent with the ~~MCE~~CCO's OHP policies, the ~~MCE~~CCO or PCP's policies for commercial members, and applicable disability discrimination laws. ~~The~~

(5) MCE ~~shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.~~

~~(f)~~Disenrollment Requests ~~by~~: Credible Threats of Violence.

(a) MCEs have the ~~MCE for~~right to request an exception to the ~~routine~~MCE initiated disenrollment ~~process shall, to the extent feasible, comply with the~~ requirements ~~set forth above in subsection (c), and shall comply with the following requirements:~~

~~(A) In accordance with 42 CFR 438.56, the MCE shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have~~outlined in section (4) of this rule when a member has committed an act of, or made a credible threat of, physical violence directed at a health care provider, the provider's staff, other patients, or the MCE~~'s~~ staff, so that it seriously impairs the MCE's ability to furnish services to either this particular member or other members .

(~~referred to below as "the incident"). A~~b) For purposes of this rule, a credible threat means that there is a significant risk that the member may cause grievous physical injury ~~to others~~ (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. ~~The MCE~~

(c) MCEs shall ~~document the reasons for the request, provide written evidence~~require their providers to ~~support~~notify both the ~~basis for the request, and document that attempts at intervention were made as described below.~~

~~(i) Providers shall~~MCE and law enforcement immediately ~~notify the MCE about the incident with the member~~when a member has acted violently or makes a credible threat of physical violence.

(A) The notification may be made to the MCE by telephone provided that such notice is followed by written notice to the MCE.

(B) Notice under this subsection (c) shall describe the ~~problem and shall be maintained for documentation purposes;~~circumstances surrounding the act or credible threat of violence and the actions taken by the provider as a result.

(~~ii~~C) ~~The MCE~~MCEs shall ~~attempt, and~~require their providers to document ~~contact with~~the incident in the member's medical record and ~~their~~the MCE shall document the provider's notice in the member's case file.

(d) The MCE shall notify the member's care team ~~regarding~~of the ~~problem and, if needed,~~act or credible threat of violence. The MCE shall involve the member's care team and ~~other appropriate individuals in the resolution~~, within the laws governing confidentiality~~;~~

~~(iii) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the MCE shall provide a written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined above. In making that determination, the MCE shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.~~

~~(iv) The MCE shall provide the following documentation:~~

~~(I) Documentation that verifies the provider or MCE immediately reported the incident to law enforcement. The MCE shall submit~~, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior.

(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence.

(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes set forth in section (4) of this rule prior to making any request for disenrollment.

(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (d) of this section (5), by following the process set forth in section (4) of this rule, the MCE shall have the right to request the member's disenrollment. The MCE's disenrollment request shall comply with all of the requirements set forth in section (4)(g) of this rule and shall also comply with all additional requirements as follows:

(A) Include an explanation of why the MCE believes the exception to following the process set forth in section (4) of this rule is necessary as it relates to an act of, or credible threat of, physical violence; and

(B) In addition to all other documentation required to be submitted under section (4) of this rule, the request must also include a copy of the police report or case number. If a police report or case number is not available, the MCE shall submit a ~~signed~~copy of the provider's entry in the member's ~~clinical~~ medical record ~~documenting the report to law enforcement or other reasonable evidence.~~

~~(II) Documentation that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others.~~

~~(H) Documentation that verifies any past incidents and attempts to accommodate similar problems with this member.~~

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

~~(B) The MCE shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;~~

~~(g) Approval or denial of routine disenrollment requests.~~

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

~~(B) In cases where the member is also enrolled in the MCE's Medicare Advantage plan, the MCE shall provide proof to the Authority of CMS' approval to disenroll the member. If approved by the Authority,~~

~~the date of disenrollment from both plans shall be the disenrollment date approved by CMS.~~, which must be signed by the provider, or a copy of the MCE's entry into the member's case file signed by the applicable MCE personnel, or both, that documents the report to law enforcement or any other reasonable evidence.

(6) Approval or Denials of MCE Requests for Disenrollment Due to Uncooperative or Disruptive Behavior, Acts of Violence, or Credible Threats of Violence.

(a) MCE requests made without all documentation, including CCO AR requests for additional or clarifying information, required under sections (4) and (5) of this rule shall be denied.

(~~c~~A) ~~If~~When there is insufficient documentation submitted with a request for disenrollment, the ~~CAR~~CCO AR shall notify the MCE of the denial within two business days of the initial ~~receipt what supporting documentation is needed for final consideration of the request.~~request.

(B) MCEs may submit a new request for disenrollment once all required documentation is completed and available to be provided to the CCO AR.

(b) After receipt of a complete MCE request for disenrollment, the request will be evaluated by the MCE's CCO AR and relevant subject matter experts, including those with licensure or certification, as well as expertise appropriate to the circumstances identified in the request for disenrollment (disenrollment review team).

~~(D) The CARs shall review the request and notify the MCE of the decision within ten working days of receipt of~~

(c) The CCO AR will document the review, recommendations, and rational with relevant regulatory or clinical criteria made by the disenrollment review team.

(A) The CCO AR shall provide the documentation and recommendations made by the disenrollment review team to Authority's management for a decision regarding disenrollment of the affected member.

(B) The documentation provided to Authority management by the CCO AR shall also include the name of all disenrollment review team members, their respective areas of expertise, licensure or certification, or both.

(C) The decision, and all individuals involved in making the decision to approve or deny an MCE request for disenrollment under this section (6) of this rule shall be documented in the affected member's case file maintained by OHA.

(d) The CCO AR shall provide written notice on Authority letterhead to the MCE of the Authority's decision to approve or deny the MCE's request for disenrollment. The CCO AR shall provide copies of the notice to the MCE CEO, MCE COO, and OHA Medicaid Director.

(A) All notices of disenrollment approvals and denials shall include the reason for the decision along with applicable, supporting regulatory or clinical criteria, or both, and identify the subject matter expertise and credentials of the disenrollment review team. However, the names of the individuals on the disenrollment review team shall not be included in the notice.

(B) When there is sufficient documentation ~~from~~for the ~~MCE.~~

~~(E) Written decisions~~CCO AR to convene a disenrollment review team, the notice of approval or disapproval of the request for disenrollment shall be ~~sent to~~made by the ~~MCE~~Authority within 15 ~~working~~business days ~~from~~of receipt of the request ~~and sufficient documentation from the CAR~~for disenrollment.

~~(h) The following procedures apply to all approved disenrollment requests made by the MCE:~~

~~(A) The CAR~~

(e) The CCO AR shall ~~send~~provide the affected member ~~a~~with written notice of their disenrollment within five business days after the ~~request was~~Authority has approved ~~with a copy~~the MCE's request for disenrollment. A copy of the member notice shall be sent to the MCE ~~and~~, which the MCE shall distribute to the member's care team. A copy of the member notice shall be placed in the member's case file maintained by the Authority. The notice of disenrollment provided to the member shall include all of the following information:

(A) The disenrollment date;

(B) The ~~notice shall give the disenrollment date, the~~ reason for disenrollment~~, and the notice of~~;

(C) Information regarding the member's right to file a ~~complaint as specified in OAR 410-141-3875 through 410-141-3905~~grievance and ~~to request an~~their administrative hearing rights; and ~~the option to continue enrollment in the MCE pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;~~

(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in OHA's record of the request and provided to the MCE for distribution the member's care team.

(~~c~~f) The date of disenrollment shall be effective ~~date shall be~~ ten calendar days after the date of the member's disenrollment notice ~~is sent to the member~~, unless ~~the~~:

(A) The member files a grievance or otherwise requests a hearing ~~and ongoing enrollment pending a hearing decision. The~~, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon ~~the issuing of an administrative law judge's decision to uphold disenrollment~~such decisions; or

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

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

(3) Other reasons for which an MCE may request disenrollment:

(a) If the member is enrolled in the MCE on the same day the member is admitted to the hospital, the MCE shall be responsible for the hospitalization and the post-hospital extended care (PHEC) benefit, as provided in 410-141-3805. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services.

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

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

(d) If the MCE determines the member has Third Party Liability (TPL), the MCE shall report the TPL to the Health Insurance Group (HIG) and HIG send the MCE an email receipt, including a tracking number. The MCE may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the MCE A or B, effective the end of the month the TPL is reported, and the member is not reflected on that month's 834 report. In some situations, the Authority may approve retroactive disenrollment.

(e) Members shall be disenrolled if out of the MCE's service area for more than three months unless previously arranged with the MCE. The effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE.

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date shall be the date the member was incarcerated.

(g) If, prior to Contract Year 2022 (or later if specified by the Authority), the member is in a state psychiatric institution;

~~(h) The member had End Stage Renal Disease at the time of enrollment in the MCE.~~

~~(4) The MCE may not disenroll members solely based on any of the following reasons:~~

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

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

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

~~(d) Because the member requests a hearing;~~

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

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

~~(5) If a member's disenrollment request is denied, the MCE shall send the member a notice of action within 14 days after the decision for denial with a copy to the member, provider, and the member's care team; the notice shall include, pursuant to OAR 410-141-3875 through 410-141-3905, notice of the member's right to file a grievance or request a hearing. For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include:~~

~~(a) Involuntary transfer of a member from one MCE to another; or~~

~~(b) Automatic enrollment of a member in a MCE.~~

(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE will be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.

(7) Enrollment for Authority Approved Disenrollment.

(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or

(b) When circumstances permit, when there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or

(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR will place an enrollment exemption for the appropriate MCE CCO-A, CCO-B,

CCO-E, and CCO-G plans and place the member on Open Card for a twelve month period, after which the CCO AR will reevaluate enrollment options for the member.

(~~6~~8) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the MCE, all ~~disenrollment's~~disenrollments are effective the end of the month the Authority approves the disenrollment.

(a) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority.

(b) If the member dies, the last date of enrollment shall be the date of the member's death.

(~~7~~9) Transfers of 500 or more members.

(a) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one MCE to another MCE if:

(A) The member's provider has contracted with the receiving MCE and the provider has stopped accepting patients from the MCE from which the member is being transferred, or has terminated providing services to members ~~in~~who are enrolled with the ~~transferring~~ MCE from which the member is being transferred;

(B) Members are offered the choice of remaining enrolled in the transferring MCE; and

(C) The member and all family (case) members shall be transferred to the provider's new MCE.

(b) The transfer shall ~~take effect when~~become effective the date on which the provider's contract with their current MCE ~~contractual relationship ends~~terminates or otherwise expires, or on ~~a~~another date approved by the Authority.

(c) Members ~~may~~shall not be transferred under this section (~~8~~9) unless the following conditions have been satisfied:

(A) The Authority has evaluated the receiving MCE and determined that the receiving MCE meets criteria established by the Authority as stated in ~~rule~~OAR 410-141-3705 including, but not limited to, ensuring that the MCE maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(B) The Authority has provided notice of a transfer to members affected by the transfer at least 90 calendar days before the scheduled date of the transfer.

Statutory/Other Authority: ORS 413.032, 414.615, 414.625, 414.635 & 414.651, 42 CFR 438.56, 42 CFR 455.13, 42 CFR 438.420
Statutes/Other Implemented: ORS 414.610 - ~~414.685~~414.68

410-141-3815 CCO Enrollment for Temporary Out-of-Area Behavioral Health Treatment Services

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

~~(a) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency.~~

~~(b) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.~~

~~(c) "Temporary Placement" means hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.~~

~~(2~~) The Authority has determined that, to the maximum extent possible, all individuals shall be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. This rule implements and further describes how the Authority administers its authority under OAR 410-141-3805 and OAR 410-141-3810 for purposes of making enrollment decisions for adult and young adult individuals, 14 through and including 17 years of age, receiving temporary out-of-area behavioral health treatment services~~.~~:

(a) For program placements in Child Welfare, Behavioral Rehabilitative Services, Oregon Youth Authority, and Psychiatric Residential Treatment Services, see OAR 410-141-3800 for program-specific rules~~.~~:

(b) For program placements in Secure Children's In-Patient (SCIP) and Secure Adolescent In-Patient (SAIP), CCOs shall work with the Authority in managing admissions and discharges~~.~~:

(c) The member shall remain enrolled with the CCO for delivery of SCIP and SAIP services. The CCO shall bear care coordination responsibility for the entire length of stay, including admission, determination, and planning.

(~~3~~2) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO or FFS on the same day the individual is admitted to the residential treatment services, the CCO or FFS shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO's service area. ~~The individual is presumed to continue to be enrolled in the CCO~~Upon discharge, FFS members will, upon the next weekly enrollment period, enroll with ~~which~~ the ~~individual was most recently enrolled~~CCO that is contracted for their residential service area.

(43) Home CCO assignment is based on the member's residence. Home CCO enrollment for temporary out-of-area placement shall:

(a) Meet Oregon residency requirements defined in OAR 410-200-0200;

(b) Comply with the CCO enrollment rules specified in OAR 410-141-3805;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to temporary placement. If the client has no enrollment history, new enrollment shall reflect most recent permanent residence prior to hospital, institutional, and residential placement; and

(d) Be consistent with OAR 410-141-3810 when the client exercises recipient choice, where the client is able to actively participate in their own recovery and direct their own care. If the client is unable to designate county of residence, as indicated in OAR 410-200-0200, the Authority shall designate the Home CCO as the geographic location of the client at the most recent residency and CCO enrollment prior to hospitalization.

(54) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:
(a) Upon State Hospital discharge, the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement.;

(b) Beginning in Contract year 2022 (or later if specified by the Authority), if the client is enrolled in a CCO at the time of the acute care admission to the State Hospital when a bed becomes available, the CCO shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO's service area. The CCO's responsibility shall be in accordance with a risk sharing agreement to be entered into between the CCO and the State Hospital, in a form required by the Authority. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(65) For new and existing temporary residential placements, CCOs shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, dentaloral, and transportation when within the scope of the CCO's contract, including when member's temporary placements are outside the CCO service area. CCO's shall coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, CCO's shall coordinate all care for accompanying dependent members.

(76) Enrollment shall follow the Home CCO enrollment policy outlined in this rule, except when:

(a) The Home CCO enrollment hinders access to care or puts the client at potential harm, or the Home CCO is unable to provide needed unique services, a change in enrollment may be

requested for the member to a CCO serving the service area of the temporary out-of-area placement; or

(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3810. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.

(~~8~~7) Pursuant to OAR 410-141-3810, if the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO. If the individual was enrolled in a different CCO in error, the Authority shall disenroll the individual from the incorrect CCO and recoup the capitation payments, pursuant to OAR 410-120-1395. Re-enrollment to the correct CCO shall occur as specified in OAR 410-141-3805.

(~~9~~8) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3810 shall apply. If the Authority determines that disenrollment should occur, the CCO shall continue to provide covered services until the disenrollment date established by the Authority, pursuant to 410-141-3860. This shall provide for an adequate transition to the next responsible coordinated care organization.

Statutory/Other Authority: ORS 413.042 & 414.610 - 414.685
Statutes/Other Implemented: ORS 413.042 & 414.610 - 414.685

410-141-3820 Covered Services ~~(Revised 8/2/19)~~

(1) General standard. The OHP Benefit Package includes treatments ~~paired with conditions~~ and health services ~~specified by Statements of Intent or Guideline Notes which are included in~~which pair together with a condition on the ~~funded portion~~same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified in any relevant Statements of Intent and Guideline Notes of the Prioritized List of Health Services. The Benefit Package also covers the additional services described in this rule.

(a) As used in OAR 410-141-3820 and 410-141-3825, the word "~~service~~health services" has the meaning given in ORS 414.025(13);

(b) Services are covered with respect to an individual member only when the services are medically or ~~dentally~~orally necessary and appropriate as defined in 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ~~410-141-3840.~~ ORS 743A.012;

(c) Benefit Package coverage of prescription drugs is discussed in OAR 410-141-3855~~.~~;

(d) The Benefit Package is subject to the exclusions and limitations described in OAR 410-141-3825.

(2) MCE service offerings~~.~~:

(a) MCEs shall offer their members, at a minimum:

(A) The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the MCE's mandatory scope of services; and

(B) Any additional services required in OAR chapter 410, or in the MCE contract.

(b) CCOs shall ~~integrate~~coordinate physical health, behavioral health and oral health care benefits~~.~~;

(c) With respect to members who are dually eligible for Medicare and Medicaid, MCEs shall provide:

(A) OHP Benefit Package services except for Medicaid-funded long-term care, services, and supports; and

(B) Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan.

(3) Diagnostic services. Diagnostic services that are medically or orally appropriate and medically or orally necessary ~~and reasonable~~ to diagnose the member's presenting condition (signs and symptoms) or guide management of a member's condition, regardless of whether the condition appears above or below the funded line on the Prioritized List of Health Services. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines on the Prioritized List of Health Services.

(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services. Preventive ~~services~~Services are ~~covered if they appear~~included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, as specified in related guideline notes. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

(6) Ancillary services. Ancillary services are covered subject to the service limitations of the OHP program rules when:

(a) The services are medically or ~~dentally~~orally necessary and appropriate in order to provide a funded service; or

(b) The provision of ancillary services will enable the member to retain or attain the capability for independence or self-care;

(c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines on the Prioritized List of Health Services.

(7) SUD services. The provision of SUD services shall comply with OAR 410-141-3545.

(8) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k.

(9) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in 410-130-0245.

(10) Coverage of services for unfunded conditions based on effect on funded comorbid conditions~~.~~:

(a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:

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

(B) The member 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.

(b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (~~8~~10)~~.~~;

(c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis~~.~~;

(d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:

(A) Treating health care provider opinion;

(B) Medical research; and

~~(C) Community standards; and~~

~~(D~~

(C) Current peer review.

(11) Ensuring that all coverage options are considered~~.~~:

(a) When a provider receives a denial for a non-covered service for any member, especially a member with a disability or with a co-morbid condition, the provider shall determine whether there may be a medically appropriate covered service to address the member's condition or clinical situation, before declining to provide the non-covered service. The provider's determination shall include consideration of whether a service for an unfunded condition may improve a funded comorbid condition under subsection (8)~~.~~;

(b) If a member seeks, or is recommended, a non-covered service, providers shall ensure that the member is informed of:

(A) Clinically appropriate treatment that may exist, whether covered or not;

(B) Community resources that may be willing to provide the relevant non-covered service;

(C) If appropriate, future health indicators that would warrant a repeat ~~diagnostic~~evaluation visit.

(c) Before an MCE denies coverage for an unfunded service for any member, especially a member with a disability or with a co-morbid condition, the MCE shall determine whether the member has a funded condition or condition/treatment pair that would entitle the member to coverage under the program.

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

(13) Ad hoc coverage determinations.

(a) If a member seeks a service pertaining to a funded condition and a funded or unfunded treatment that ~~do~~does not pair with the same condition on the HERC Prioritized List of Health Services, and coverage is not otherwise available pursuant to this ~~section,~~rule, or excluded by any applicable statute, and the member~~'s~~ requests an appeal from their MCE ~~—~~or ~~for~~a hearing from fee for service, the ~~medical review unit may seek a coverage~~MCE or Division must make an ad hoc determination ~~from the Division~~on an individual basis as to whether the treatment may be medically or orally appropriate and necessary for the member;

(b) If the member requests a hearing the Division determines ~~that~~whether the HERC has ~~not~~ considered the funded condition/treatment pair for inclusion on the Prioritized List within the last five years. If the HERC has not considered the pair for inclusion within the last five years, the Division shall make an ad hoc coverage determination in consultation with the HERC:

(A) If the Division decides the requested treatment is appropriate and necessary, before the hearing the Division will make the following determinations:

(i) Is the condition funded on the HERC Prioritized List of Health Services;

(ii) Is the treatment on the HERC Prioritized List of Health Services, funded or unfunded;

(iii) Is the treatment that does not pair with the member's condition medically or orally appropriate and necessary for the member; and

(iv) Has the HERC considered the funded condition/treatment pair for inclusion on the Prioritized List and determined it is not covered.

(B) If the Division determines that (A)(i) or (ii) or (iii) is not met, the Division will uphold the denial and not proceed to (iv). The member may then proceed to hearing;

(C) If the Division determines that (A)(iv) is met the Division will uphold the denial. The member may then proceed to hearing;

(D) If the Division determines that (A)(i), (ii) and (iii) are met and (A)(iv) is not met, the Division will overturn the denial and approve the coverage by exception. This determination will not need to proceed to hearing.

(c) If ~~an MCE disagrees with the~~a Division hearing overturns a MCE's coverage determination, the MCE may invoke the dispute resolution procedures in OAR 410-141-3550.

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

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3825 Excluded Services and Limitations ~~(Revised 8/2/19)~~

(1) The following services are excluded from the Oregon Health Plan Benefit Package, except as otherwise provided in OAR 410-141-3820:

(a) Any service identified for exclusion in OAR 410-120-1200 or 410-120-1210;

(b) Any service identified in ~~the appropriate~~applicable provider guides as a non-covered service, unless the service is identified as specifically covered under the OHP administrative rules;

(c) Any service that is not a funded service, even if it is provided for a condition that appears in the funded region of the list, or if the service in question is a funded service when provided for an unfunded diagnosis on the prioritized list;

(d) Services that, when provided, are funded services on the Prioritized List of Health Services, but which are otherwise excluded from the OHP Benefit Package for the client in question;

(e) Diagnostic services not reasonably necessary to establish a diagnosis or guide management or treatment decisions, regardless of whether the condition or treatment in question is a funded service;

(f) Services requested by OHP clients in an emergency care setting that do not satisfy the coverage rules in OAR 410-141-3820;

(g) Services provided to an OHP client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(h) Services other than inpatient care provided to an OHP client 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 410-141-3810;

(i) Services received while the client is outside the MCE's service area, except for services that were:

(A) ~~Authorized~~Ordered or referred by the client's primary care provider; or

(B) Urgent or emergency services; or

(C) Otherwise covered pursuant to rule or the MCE contract~~.~~;

(D) This exclusion does not apply if the client was outside the MCE's service area because of circumstances beyond the client's control. Factors to be considered include but are not limited to death of a family member outside of the MCE's service area. If the client successfully establishes this fact, including during the grievance and appeal process, then this exclusion does not apply.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are medically appropriate and necessary to~~:~~ provide reasonable diagnosis and treatment; enable the OHP client to attain or retain the capability for independence or self-care; or screen for preventable disease or disease exacerbation. This limitation includes services that, upon medical review, could not reasonably have been expected to provide more than 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 OHP Prioritized List of Health Services;

(c) Services that are limited under OAR 410-120-1200 and 410-120-1210.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3830 Prioritized List of Health Services

(1) The Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and behavioral health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their ~~websitehttps~~website: https://www.oregon.gov/OHA/HPA/~~CSI~~DSI-HERC/Pages/Prioritized-List.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule, effective January 1, ~~2019~~2020, incorporates by reference new interim modifications to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2018–December 31, 2019, Prioritized List funded through line 469. This amended Prioritized List includes revised line items and new/revised guideline notes, statements of intent, coding specifications, and annotations that supersede those found in the ~~October~~January 1, ~~2018~~2019, Prioritized List.

Statutory/Other Authority: ORS 413.042 ~~&~~and ORS 414.065
Statutes/Other Implemented: ORS 414.065 ~~&~~and ORS 414.727

410-141-3835 MCE Service Authorization ~~(Revised 8/2/19)~~

(1) Coverage of services is outlined by MCE contract and OHP benefits coverage in OAR 410-120-1210 and 410-120-1160.

(2) A member may access urgent and emergency services 24 hours a day, seven days a week without prior authorization.

(3) The MCE may not require a member to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. A member may self-refer to behavioral health and services available from the provider network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.

(4) Contractors must permit out-of-network IHCPs to refer an MCE-enrolled Indian to a network provider for covered services as required by 42 CFR 438.14(b)(6).

(5) The MCE shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-3830.

(6) MCEs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(7) MCEs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. ~~MCES~~MCEs shall observe required timely access to service timelines as indicated in OAR 410-141-3515.

(8) MCEs may place appropriate limits on a service authorization based on medical necessity and medical appropriateness as defined in OAR 410-120-0000 or for utilization control provided that the MCE:

(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

(b) Authorizes the services supporting individuals with ongoing or chronic conditions or ~~require~~those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;

(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20 and

the member's free choice of provider consistent with 42 USC §1396a(a)(23)(B) and 42 CFR §431.51; and

(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.

(9) For authorization of services:

(a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:

(A) For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:

(i) The member, the member's representative, or provider requests an extension; or

(ii) The MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

(B) For notices of ~~actions/~~adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least ~~ten~~10 days before the date the adverse benefit determination takes effect:

(i) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;

(ii) The MCE may extend the 72-hour period up to 14 days if the member requests an extension or if the MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

(b) Prior authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the MCEs as follows:

(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. An initial response shall include:

(i) A written, telephonic or electronic communication of approval of the drug as requested to the member, pharmacy, and prescribing practitioner; or

(ii) A written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the pharmacy and the prescribing practitioner if the drug is denied or partially approved; or

(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the MCE's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or

(iv) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay a decision to approve or deny the drug within 72 hours.

(B) The 72-hour window for a coverage decision begins with the initial date~~/~~ and time stamp of a prior authorization request for a drug~~.~~;

(C) If the response is a request for additional documentation, the MCE shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:

(i) Upon receiving the MCE's completed prior authorization forms and required documentation, the MCE shall issue a decision as expeditiously as the member's health requires, but no later than 72 hours from the date~~/~~ and time stamp of the initial request for prior authorization as follows:

(I) If the drug is approved as requested, the MCE shall notify the member~~,~~ in writing and the pharmacy and prescribing practitioner ~~in writing,~~ telephonically, or electronically; or

(II) If the drug is denied or partially approved, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the pharmacy and the prescribing practitioner~~; and~~.

(ii) If the requested additional documentation is not received within 72 hours from the date~~/~~ and time stamp of the initial request for prior authorization, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the pharmacy and prescribing practitioner.

(D) The MCE shall provide approved services as expeditiously as the member's health condition requires~~.~~;

(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the MCE makes a coverage decision.

(c) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;

(d) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;

(e) MCEs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR §438.404 and OAR 410-141-3885;

(f) The MCE and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:

(A) MCEs shall consult with the requesting provider for medical services when necessary:

(i) Requesting all the appropriate information to support decision making as early in the review process as possible; and

(ii) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.

(B) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:

(i) Deny a service authorization request;

(ii) Reduce a previously authorized service request; or

(iii) Authorize a service in an amount, duration, or scope that is less than requested.

(C) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify timeframes for the following:

(i) Date and time stamping prior authorization requests when received;

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

(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;
(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(v) Providing services after office hours and on weekends that require prior authorization.

(D) An MCE shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to:

(i) Drugs;

(ii) Alcohol;

(iii) Drug services; or

(iv) Care required while in a skilled nursing facility.

(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within 14 days of receipt of the request as set forth in OAR 410-141-3885 unless otherwise specified in OHP program rules:

(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the 14-day period;

(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;

(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

Statutory/Other Authority: 413.042, 414.065, 414.651, 414.615, 414.625 & 414.635
Statutes/Other Implemented: 414.065 & 414.610-414.685

410-141-3840 Emergency and Urgent Care Services

(1) CCOs shall have written policies, 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 members. CCOs 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 compliance. CCOs shall document all monitoring and corrective action activities.

(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or ~~dentally~~orally appropriate response as indicated to urgent or emergency calls including but not limited to the following:

(a) Telephone or face-to-face evaluation of the member;

(b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;

(c) Development of a course of action;

(d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound;

(e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and

(f) Provision for notifying other providers~~, when necessary, to request approval to treat members~~ that prior authorization is required for post-stabilization care in accordance with this rule.

(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the 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 CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.

(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard,

the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:

(a) The CCO 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-emergent;

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

(c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not timely billed ~~within ten calendar days of~~for the service.

(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, whether for physical, behavioral, or oral health, whether in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:

(a) Pre-authorized by the CCO;

(b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or

(c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.

(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:

(a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's care;

(b) The participating provider assumes responsibility for the member's care through transfer;

(c) A CCO representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for ~~dental~~oral health care~~.~~:

(a) CCOs shall educate members about, and support them in, how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;

(b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.

(8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3845 Health-Related Services

(1) The goals of health-related services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services.:

(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below.:

(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule.:

(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;

(d) HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, or tribal-based services.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 4245 C.F.R. § 158.150:

(a) The service must be designed to:

(A) Improve health quality;

(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(D) Be based on any of the following:

(i) Evidence-based medicine; or

(ii) Widely accepted best clinical practice; or

(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(D) Implement, promote, and increase wellness and health activities;

(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(c) The following types of expenditures and activities are not considered HRS:

(A) Those that are designed primarily to control or contain costs;

(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;

(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;

(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;

(F) All retrospective and concurrent utilization review;

(G) Fraud prevention activities;

(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(I) Provider credentialing;

(J) Costs associated with calculating and administering individual member incentives; and

(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.

(3) CCOs shall implement policies and procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval. :

(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability. :
(b) A CCO's HRS spending on community benefit initiatives shall align promote alignment with the priorities identified in the CCO's community health improvement plan. CCOs will align, and with any HRS community benefit initiatives spending with any HRS CBI initiative spending priorities identified by the Authority. :

(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in community benefit initiatives spending decisions. ;

(d) MCEs CCOs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.

(4) Flexible services are cost-effective services offered to an individual member as an adjunct to supplement covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care. These services shall be documented in the member's treatment plan and clinical record. :

(a) CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;

(a b) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915. CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf;

(b) The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome.

(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality.

~~(a)~~ CCOs shall designate a role for the community advisory council in directing, tracking, and reviewing community benefit initiatives, as provided in OAR 410-141-~~AAAA [new SDOH-HE rule].~~ ~~(b) Community benefit initiatives that are initiated by the CCO shall, for documentation purposes, be included in the CCOs' Transformation and Quality Strategy mid-year update and annual reports. Community benefit initiatives may not be documented in a treatment plan or clinical record~~3735.

(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).

(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

410-141-3850 Transition of Care

(1) This rule applies to care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after disenrollment from a "predecessor plan," which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). This rule does not apply to a member who is ~~disenrolled from~~ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.

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

(a) "Continued Access to Care" means, during a member's transition of care from the predecessor plan to the receiving CCO, providing access without delay to:

(A) Medically necessary covered services;

(B) Prior authorized care;

(C) Prescription drugs; and

(~~c~~D) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.

(b) "Medically Fragile Children" as defined by OAR 411-350-0020 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);

(c) "Prior Authorized Care" means covered services that were authorized by the predecessor plan. This term does not, however, include health-related services approved by the predecessor plan~~.~~;

(~~c~~d) "Transition of Care" means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to care. The transition of care period lasts for:

(A) Ninety days for members who are dually eligible for Medicaid and Medicare; or

(B) For other members, the shorter of:

(i) Thirty days for physical and oral health and ~~sixty~~60 days for behavioral health; or

(ii) Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan.

(3) CCOs must implement and maintain a transition of care policy that, at a minimum, meets the requirements defined in this rule and 42 CFR § 438.62(b). A receiving CCO must provide continued access to care to, at minimum, the following members:

(a) Medically ~~fragile children~~Fragile Children;

(b) Breast and Cervical Cancer Treatment program members;

(c) Members receiving CareAssist assistance due to HIV/AIDS;

(d) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and

(e) Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

(4) Receiving CCO obligations during the transition of care period~~.~~:

(a) The receiving CCO shall ensure that any member identified in section (3) has continued access to care~~.~~ and Non-Emergency Medical Transportation (NEMT);

(b) The receiving CCO shall permit the member to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's network, until one of the following occurs:

(A) The minimum or authorized prescribed course of treatment has been completed; or

(B) The reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider.

(c) Notwithstanding section~~)~~ (4)(b), the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:

(A) Prenatal and postpartum care;

(B) Transplant services through the first-year post-transplant;

(C) Radiation or chemotherapy services for the current course of treatment; or

(D) Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.

(d) Where this section (4) allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates~~.~~:

(e) The receiving CCO is not responsible for paying for inpatient hospitalization or post hospital extended care for which a predecessor CCO was responsible under its contract.

(5) After the transition of care period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.

(6) A receiving CCO shall obtain written documentation as necessary for continued access to care from the following:

(a) The Authority's clinical services for members transferring from FFS;

(b) Other CCOs; and

(c) Previous providers, with member consent when necessary.

(7) During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization of ongoing covered services~~.~~:

(a) CCOs shall not delay service authorization for the covered service if written documentation of prior authorization is not available in a timely manner~~.~~;

(b) In such instances, the CCO is required to approve claims for which it has received no written documentation during the transition of care time period, as if the covered services were prior authorized.

(8) The predecessor plan shall comply with requests from the receiving CCO for complete historical utilization data within ~~21~~seven calendar days of the ~~member's effective date with~~request from the receiving CCO.

(a) Data shall be provided in a ~~HIPAA compliant format to facilitate continued access to care.~~secure method of file transfer;

(b) The minimum elements provided are:

(A) Current prior authorizations and pre-existing orders;

(B) Prior authorizations for any services rendered in the last 24 months;

(C) Current behavioral health services provided;

(D) List of all active prescriptions; and

(E) Current ICD-10 diagnoses.

(9) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR §438.404 and OAR 410-141-3885.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3855 Preferred Drug List ~~(Revised 7/30/19)~~

(1) Prescription drugs are a covered service for conditions that are described in the funded region of the Prioritized List of Health Services, as described in OAR 410-141-3820. MCEs shall pay for covered 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~~section (~~13), (14), and (15~~10) of this rule;

(c) Drugs covered under Medicare Part D when the ~~client~~member is fully dual eligible; and

(d) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act, for which payment is governed by OAR 410-121-0150.

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

(3) MCEs may use a ~~restrictive~~preferred drug list if it allows access to other drug products not on the drug list through prior authorization ~~(PA). The restrictive drug list must align with the Fee-for-Service Preferred Drug List for any and all medications in drug classes required by OHA. Such alignment must include:~~
~~(a) Identical preferred and non-preferred status; and~~.

~~(b) Identical criteria for Prior Authorization for all medications on the PDL.~~

(4) As specified in 45 CFR 156.122 and 42 CFR 438.10, MCEs 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 way certain drugs may be obtained. MCEs shall ensure that:

(~~5~~a) ~~As specified in 45 CFR 156.122, the~~The preferred drug list ~~must:~~
~~(a) Exist in a manner~~is easily accessible to members and potential members, state and federal government, and the public;

(b) ~~Be~~The preferred drug list is accessible on the ~~plan~~MCE's public website in a machine-readable format through a clearly identifiable web link or tab without requiring ~~an individual~~a member to access account or policy number;

(c) Be made available in paper form if requested by a member; and

(d) If ~~the issuer~~an MCE has more than one plan, ~~the member shall~~members may be easily able to discern which ~~of the~~ preferred drug ~~lists~~list applies to which plan.

(~~6~~5) 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~~6) MCEs shall cover at least one form of contraception within each of the ~~eighteen~~18 methods identified by the FDA. As set forth in OAR 410-141-3515, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating ~~provider.~~

~~(8) MCEs 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.~~

(~~9~~7) Prior authorization for prescription drug requests shall be addressed by the MCEs as described in OAR 410-141-3835.

(~~10~~8) MCEs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the 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.

(~~11~~9) MCEs 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. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the federal "Drug Products in the Medicaid Drug Rebate Program" list available at:

~~https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e~~https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e

(~~12~~10) 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), unless otherwise provided in this rule. An MCE may not reimburse providers for carved-out drugs~~.~~:

(a) An MCE may seek to add drugs to the carve-out 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 the following information:

(A) The drug name;

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

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

(b) If the Authority approves an MCE request for a drug not to 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.

(~~13~~11) MCEs shall submit quarterly ~~utilization~~encounter data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.

(~~14~~12) MCEs 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. MCEs 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.

(~~15~~13) MCEs shall utilize a pharmacy~~,~~ and therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, if all committee requirements for both committee types are met~~.~~:

(a) A P&T committee must 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. ;

(b) MCEs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations. ;

(c) The committee in its DUR capacity shall assure prescriptions are appropriate, medically appropriate, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined and described by 42 CFR 456, subpart K. and Section 1902(oo) of the Social Security Act [42 U.S.C. 1396a(oo)].

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610–414.685

410-141-3860 Integration and Coordination of Care

(1) In order to achieve the objectives of providing ~~MCE~~CCO members integrated person-centered care and services, ~~MCEs~~CCOs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs shall be required to document and report on the requirements in this rule in accordance with section (20) of this rule.

(2) ~~MCEs~~CCOs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.

(3) ~~MCEs~~CCOs shall coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:

(a) With the services the enrollee receives from any other ~~MCE~~CCO;

(b) With the services the enrollee receives in FFS Medicaid; and

(c) With the services the enrollee receives from community and social support providers.

(4) ~~MCEs~~CCOs shall develop evidence-based and, whenever possible, innovative flexible and creative strategies, for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.

(5) To the maximum extent feasible, ~~MCEs~~CCOs shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs by:

(a) Making PCPCHs ~~shall become~~ the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) ~~MCEs shall develop~~Developing and implementing mechanisms that encourage providers to communicate and coordinate care with ~~the PCPCH~~PCPCHs in a timely manner, using electronic health information technology ~~where~~when the technology is available; and

(c) ~~MCEs shall engage~~Engaging other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.

~~(d) CCOs shall administer the patient-centered primary care home program and receive program required reporting as supposed by OAR 409-055-0000 through 409-055-0090 and the CCO contract.~~

(6) If ~~an MCE~~, in addition to the use of PCPCH, a CCO implements other models of patient-centered primary health care ~~in addition to the use of PCPCH~~, the ~~MCE~~CCO shall ensure member access to effective coordinated care services that ~~provide effective~~include wellness and prevention~~, coordination of care~~ services, active management and support of ~~individuals~~members with special health care needs, ~~a~~ patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. ~~The MCE~~To that end the CCO shall be required to:

(a) ~~Demonstrate that~~Ensure each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible ~~MCE~~CCO participating provider type. If the member does not choose a primary care provider or primary care team within 30 calendar days from the date of enrollment, the ~~MCE~~CCO shall ensure the member has an ongoing source of primary care appropriate to their needs by formally designating a practitioner or entity. CCOs shall document in each member's case file all efforts made in accordance with this subsection (a);

(b) Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided with information on how to contact their designated person or entity;

(c) ~~MCEs shall develop~~Develop services and supports for primary and behavioral health care that ~~are geographically located as close as possible to the member's residence~~meet the access to care requirements set forth in OAR 410-141-3515 and which are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. ~~MCEs~~CCOs shall also ensure that all other services and supports ~~are provided as close to the member's residence as possible.~~meet the access to care requirements set forth in OAR 410-141-3515; and

(d) ~~MCE~~Allow eligible members who are Indians ~~shall be permitted~~ to select ~~an~~as their primary care provider:

(A) An Indian health care provider (IHCP) ~~that~~who is ~~participating as~~ a primary care provider within the CCO's provider network ~~of the MCE~~; or ~~may select an~~

(B) An out-of-network IHCP from whom the ~~enrollee~~member is otherwise eligible to receive such primary care services.

(7) MCEs shall establish and enter into hospital and specialty service agreements that include the role of ~~patient-centered primary care homes~~PCPCHs and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for after-hospital follow up appointments.

(8) ~~MCEs~~CCOs shall meet all of the following requirements relating to transitions of care:

(a) ~~MCEs shall demonstrate how~~Require hospitals and specialty services ~~shall~~to be accountable ~~to achieve~~for achieving successful transitions of care~~. MCEs shall ensure~~;

(b) Ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the State Hospital~~.~~;

(~~b~~c) When a member's care is being transferred from one ~~MCE~~CCO to another or for OHP clients transferring from fee-for-service to ~~an MCE~~a CCO, the ~~MCE~~CCO shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an ~~MCE~~CCO participating provider~~.~~;

(~~c~~d) ~~The MCE shall implement~~Implement systems to assure and monitor transitions in care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the ~~process~~processes for members accessing care coordination~~.~~;

(~~d~~e) For members who are discharged to post hospital extended care ~~at the time of admission~~by being admitted to ~~a~~ skilled nursing facility (SNF), the ~~MCE~~CCO shall notify the appropriate Department office and begin appropriate discharge planning. The ~~MCE~~CCO shall pay for the full 20-day post-hospital extended care benefit when ~~appropriate~~the full 20 days is required by the discharging provider, if the member was enrolled in the ~~MCE~~CCO during the hospitalization preceding the nursing facility placement:

(A) ~~MCEs~~CCOs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC) that the post-hospital extended care will be paid for by the CCO;

(B) For members who are discharged to Medicare Skilled Care Unit within a SNF, the ~~MCE~~CCO shall notify the appropriate Department office when the ~~MCE~~CCO learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care; and

(C) ~~MCEs~~CCOs shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.

(~~e~~f) ~~MCEs~~CCOs shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs (as defined under OAR 309-032-0860(30)) between levels or episodes of care. Specific requirements for ~~MCE~~CCO care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.

(9) ~~MCEs~~CCOs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs as follows:

(a) ~~The MCE shall establish~~Establishing procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of ~~MCE~~CCO services with long-term care services and crisis management services;

(b) ~~MCEs shall develop a Memorandum of Understanding~~Developing and entering into memoranda of understanding (~~MOU~~MOUs) or ~~contract~~contracts with the local type B Area Agency on Aging or the local office of the Department's APD~~, detailing~~ that details their system coordination agreements regarding members receiving Medicaid-funded LTCSS; and

(c) ~~MCEs shall establish agreements~~Developing and entering into MOUs or contracts with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget.

(10) ~~An MCE may~~CCOs shall cover and reimburse inpatient psychiatric services, ~~not including substance use disorder treatment~~except when those services are provided at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010~~. (See~~ and OAR 410-141-3500 ~~for the definition of an IMD.)~~ The state may, however, make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services ~~for~~provided at an IMD as an alternative ~~service or~~ setting~~, incorporating~~ to those covered under the state plan, when all of the following requirements ~~as defined~~are met in accordance with 42 CFR 438.6(e):

(a) ~~For members~~The member receiving services is aged 21-64;

(b) ~~As inpatient psychiatric~~The services are provided for a short-term ~~stay~~ of no more than 15 days during the period of the monthly capitation payment; and

(c) The provision of ~~inpatient psychiatric~~ services ~~in an~~at the IMD ~~shall meet~~meets the requirements for "in lieu of services" as ~~defined~~set forth in 42 CFR 438.6(e)(2)(i) through (iii), which requires all of the following:

(A) The ~~alternative service or setting~~IMD is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;

(B) The ~~MCE~~CCO must offer members the option to access the state plan services and ~~may~~shall not require ~~a member~~members to use the IMD as an alternative service or setting; and

(C) The approved in lieu of services are authorized and identified in the ~~MCE contract~~CCO contracts and ~~may be~~ offered to members at the ~~MCE~~CCO's option.

(11) If ~~the~~a member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the ~~MCE~~CCO shall communicate with

the member and the Department Medicaid funded long-term care provider or facility about integrated and coordinated care services.

(12) ~~An MCE~~CCOs shall ~~demonstrate that~~ensure their participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. The ~~MCE~~CCOs shall also ~~demonstrate ability to~~ensure that they facilitate information ~~exchange~~exchanges between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). Compliance with the requirements under this section (12) shall be documented and reported to the Authority in the form and manner required by the Authority in accordance with OAR 410-141-3525:

(a) ~~MCE~~CCOs shall require that providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with their Health Equity Plan Training and Education described in 410-141- ~~AAAA SDOH/HE (4)~~ 3735;

(b)~~.~~
~~(b) The MCE~~ CCOs shall communicate ~~its~~their integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. ~~MCEs~~CCOs shall document all monitoring and corrective action activities.

(13) ~~MCEs~~CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. ~~MCEs~~CCOs shall coordinate the care of members ~~that~~who enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the ~~state hospital~~Oregon State Hospital and when they are transitioning ~~from~~out of the Oregon State Hospital.

(14) ~~MCEs~~Except as provided in OAR 410-141-3800, CCOs shall coordinate a member's care outside the CCO's service area or, when medically necessary specialty care is not available in Oregon, out-of-state care. CCOs shall coordinate member care even when services or placements are outside the ~~MCE~~CCO service area~~. MCE assignment is based on the case member's residence and referred to as county of origin or jurisdiction~~. Temporary placements by the Authority, Department, or providers who are responsible for health ~~services~~service placements for services including residential placements, may be located ~~out of~~outside the service area; however, the ~~MCE~~CCO shall coordinate care while in placement and discharge planning for return to the ~~county of origin or jurisdiction~~home CCO. For out of service area placements, an ~~out of area~~ exception shall be made for the member to retain ~~the MCE~~home CCO enrollment ~~in the county of origin or jurisdiction,~~ while the member's placement is a temporary residential placement elsewhere~~. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3800 for program specific rules.~~

~~(15) Except as provided in OAR 410-141-3800, MCEs shall coordinate patient care, including care required by temporary residential placement outside the MCE service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon~~:

(a) ~~MCE enrollment~~CCOs shall ~~be maintained in the county of origin with the expectation of the MCE,~~ prior to discharge, coordinate care in accordance with ~~the out of area placement and local providers; (b) The MCE shall coordinate the~~a member's discharge ~~planning~~plan when the member returns to ~~the county of origin.~~their home CCO; or

(~~c~~b) If a member loses Medicaid coverage while in an episode of care, the care coordinator will continue to manage the member's care until Medicaid coverage resumes.

(~~16~~15) ~~MCEs~~CCOs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the ~~MCE~~CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The ~~MCE~~CCO shall pay for the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 ~~MCE~~CCO Service Authorization.

(~~17~~16) ~~MCEs~~CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing ~~a~~ behavioral health ~~crisis~~crises and to prevent inappropriate use of the emergency department or jails.

(~~18~~17) ~~MCEs~~CCOs shall perform care coordination in a manner that is trauma-informed and culturally responsive, as those terms are defined in OAR ~~309-035-0105~~410-141-3500.

(~~19~~18) ~~MCEs~~CCOs shall ~~monitor the effectiveness of their integration and care coordination efforts. MCEs must~~ implement at least ~~1~~one outcome measure tool for care coordination services at the ~~PCP-managed Care Coordination level and one at the~~ ICC Care Coordination level~~)~~. CCOs shall collaborate with the Authority to develop statewide standards for care coordination and ICC.

(~~20~~19) ~~The MCE must report semiannually to the Authority on its~~CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a report submitted to the Authority semi-annually. The ~~MCE~~CCO is subject to appropriate corrective action by the Authority if the contents of the report reveal that the ~~MCE~~CCO's care coordination requirements are not being met. ~~The~~For each reporting period the report must contain:

(a) ~~An identification~~Identification of care coordination practices used with members and the frequency with which each of those practices were used;

~~(b~~

(b) Identification of the number of members receiving ICC services, the type of ICC services provided, and the demographics of such members;

(c) An overall review of care coordinators performing services for the ~~MCE~~CCO, separated by employed and delegated or subcontracted care coordinators;

(~~c~~d) Identification of any significant events that occurred to members, including, without limitation:

(A) Incarceration;

~~(d~~

(B) Reassessment triggers; and

(C) Sentinel events;

(e) Data on the type and frequency of reassessment triggers ~~for re-assessment exhibited within the reporting period;~~
~~(e) Activity logs of Care Coordination services~~;

(f) Plans and strategies to improve care coordination with network providers; ~~and~~

(g) Reports of member grievances related to care coordination with corrective action plans to improve common grievances~~.~~;

~~(21) The MCE must identify a~~

(h) Identification of milestones and accomplishments; and

(i) A plan to improve the overall process of care coordination access for its Members. ~~This~~The plan shall also include discussion of gaps in care coordination services and populations that need additional support and plans for improving the care coordination system within their CCO. ~~This~~The plan is subject to approval by the ~~MCE board and must be updated semiannually with milestones and accomplishments~~CCOs' governing boards.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610–414.685

410-141-3865 Care Coordination Requirements

(1) ~~The CCO~~CCOs will ensure continuous care management for all members~~, not only those in ICC or specialized programs, through episodes of care, regardless of the physical location of the member~~.

(2) ~~The MCE~~CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member in accordance with OAR 410-141-3870. This screening is distinct from the assessment of special health care needs~~.~~ ;

(a) ~~MCEs~~CCOs must use a universal screening process ~~that assesses~~to evaluate all members for critical risk factors that trigger the need for intensive care coordination for ~~high-needs~~ members~~.~~ with special health care needs;

(b) Members shall be screened upon initial enrollment with ~~the MCE~~their CCO. This screening shall be completed ~~and documented as quickly as the member's health condition requires, but at least within~~as follows:

(A) Within 90 days of the effective date of initial enrollment ~~for all new members, or within~~;

(B) Within 30 days of the effective date of initial enrollment when the member is ~~referred or is receiving~~:

(i) Referred; or

(ii) Receiving Medicaid-funded long-term care, services~~,~~ and supports (LTCSS); or ~~is~~

(iii) Is a member of a priority population ~~for ICC,~~ as ~~described~~such term is defined in OAR 410-141-3870(2); or

(C) Sooner than required under (A) or (B) if required by the member's health condition.

(c) ~~Members~~CCOs shall ~~be reassessed~~rescreen members annually~~, upon a change in responsibility,~~ or sooner if there is a change in health status indicating need for an updated assessment. Members shall be rescreened in accordance with this section (c) even if they have previously declined care coordination or ICC services;

~~(d) MCEs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention, and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues, or when a member overutilizes services.~~

~~(e) MCEs shall maintain documentation of~~

(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;

(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.

(3) CCOs shall document all ~~completed~~screenings and assessments~~. If~~ in the ~~MCE~~member's case file:

(a) If a CCO requires additional information from the member to complete ~~an~~a screening or assessment, the ~~MCE~~CCO shall document all attempts to reach the member by telephone and mail~~.~~;

~~(f) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document the screening in the member's record. An MCE~~

(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;

(c) CCOs shall share the results of ~~its assessment,~~member assessments and screenings consistent with ORS 414.679 and all other applicable state and federal privacy ~~requirements~~laws with the following:

(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;

(B) The state or other MCEs serving the member;

(C) Members receiving ~~Medicaid-funded~~ LTCSS and, if approved by the member, their case manager and their LTCSS provider, if approved by the member; and

(D) With Medicare Advantage plans serving dual eligible members.

(~~3~~4) ~~MCEs~~CCOs shall have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and ~~identify appropriate~~for identifying those members ~~for referrals~~requiring referral to the Department for ~~long-term services and supports~~LTSS.

(~~4~~5) ~~MCEs'~~CCOs shall require their care coordinators shall develop, and ~~MCEs~~CCOs shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ~~intensive care coordination~~ICC needs, including ~~members~~those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving ~~Medicaid-funded~~ LTCSS.

(~~5~~6) A member's care plan must at a minimum:

(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners~~.~~;

(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member.;

(c) Make provision for authorization of services in accordance with OAR 410-141-3835 MCE Service Authorization.;

(d) Be developed within 30 days and updated annually for all members not in ICC or a specialized program. For members enrolled in ICC or a specializedcondition-specific program, intensive care coordination plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care plan needs change.

(67) Care plans shallmust reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals.:

(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;

(ab) To ensure engagement and satisfaction with care plans, care coordinators shall:

(A) Actively engage members shall participate in the creation of care plans.;

(b) Members must be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan.

(B) Ensure members understand their care plans; and

(C) Ensure members understand their role and responsibilities outlined in their care plans.

(c) Care coordinators shall actively engage members and caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities.;

(d) If a member's participation in creating a member's care plan would be significantly detrimental to the member's care or health, athe member, the member's caregiver, or the member's family may be excluded from the development of a care plan and denied access to. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as above;

(e) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providing the member with a copy of thetheir care plan. The MCE would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the exclusioncare plan, including a specific description of the risk or potential harm to the member, and describe

what attempts ~~have been~~were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the ~~exclusion must~~care plan shall be documented as above.

(~~7~~8) A member may decline care coordination and ICC. ~~The MCE~~CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

(~~8~~9) ~~An MCE's care~~Care coordinators ~~must~~shall perform their care coordination tasks in accordance with the following principles:

(a~~) A care coordinator will:~~

~~(~~A) Use trauma informed~~ care~~, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-being;

(~~B~~b) ~~Set~~Work with members to set agreed-upon goals ~~for the member~~ with continued CCO network support for self-management goals;

(~~C~~c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;

(~~D~~d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;

(~~E~~e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;

(~~F~~f) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and

(~~G~~g) Have contact with, if the member is participating in a condition-specific program, the active ~~program~~condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

(~~b~~10) Care coordinators shall promote continuity of care and recovery management through:

(~~A~~a) ~~Shall continue through episodes~~Episodes of care, regardless of the member's location ~~of individual~~;

(~~B~~b) Monitoring of conditions and ongoing recovery and stabilization;

(~~C~~c) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and

(~~D~~d) Engaging members, and their family and caregivers as appropriate.

(~~9~~11) ~~An MCE~~CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860, care coordinators ~~must take the following steps to~~shall facilitate transitions and ensure applicable services continue after discharge~~:~~ by taking the steps set forth below.

(a) ~~The member's care coordinator must participate and play~~Taking an active role in discharge planning from a ~~specialized~~condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities.

(b) For discharges from the State Hospital and residential care, the care coordinator shall ~~have~~do all of the following:

(A) Have contact with the member no less than ~~2~~two times per month prior to discharge and ~~2~~two times within the week of discharge~~. Care coordinators must attempt to engage~~;

(B) Assist in the facilitation of a ~~face-to-face~~ warm handoff to relevant care providers during transition of care and discharge planning~~. The care coordinator shall also engage~~; and

(C) Engage with the member, face to face, within ~~2~~two days post discharge.

(c) For discharges from an acute care admission, the care coordinator shall have contact with the member ~~within 1~~on a face-to-face basis whenever possible, as follows:

(A) Within one business day of admission~~, 2~~;

(B) Two times ~~a~~per week while the member is in acute care~~,~~; and ~~no~~
(C) No less than ~~2~~two times ~~a~~per week within the week of discharge~~, on a face-to-face basis if possible~~.

(d) Prior to discharge~~, CCOs will~~ from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan. This meeting must be held 30 days prior to the member's return to the ~~Contractor Service Area , 30 days prior to discharge,~~CCO's service area or, if applicable, to another facility or program or as soon as possible if the ~~MCE~~CCO is notified of impending discharge or transition with ~~fewer~~less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue~~.~~;

(e) ~~The COO~~CCOs must oversee management of all members who have had a lapse in Medicaid coverage, ~~and~~ work to establish services that may be needed but currently are not available in their ~~region~~service areas, and if eligible, assist in the reinstatement of Medicaid coverage.

(~~f~~12) ~~The MCE must~~CCOs shall supervise care coordinators to ensure they are providing the required and appropriate behavioral, oral, and physical health care services and supports to members ~~and provide full oversight and supervision to the assigned care coordinators~~. The individual(s) tasked with ~~such~~ responsibility ~~must~~for supervising care coordinators shall be a licensed master's-level mental health professional. ~~This supervisory responsibility cannot be delegated or subcontracted outside of the CCO, and the CCO itself must hold~~CCOs shall not subcontract or otherwise delegate its obligation to provide care coordination services nor shall CCOs subcontract or otherwise delegate the responsibility for supervising care coordinators ~~responsible for ensuring integrated coordination of care~~.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610–414.685

410-141-3870 ~~410-141-3870~~ Intensive Care Coordination

(1) ~~MCEs~~CCOs are responsible for ~~intensive care coordination~~Intensive Care Coordination (ICC) services. The requirements described ~~herein~~in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 and 410-141-3865.

(2) "Prioritized Populations" means individuals ~~with SPMI, children 0-5 at risk of maltreatment, children~~who:
~~showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis, individuals in medication assisted treatment for SUD, pregnant women and parents with dependent children, children with neonatal abstinence syndrome, children in Child Welfare, IV drug users, individuals with SUD in need of withdrawal management, individuals with HIV/AIDS, individuals with tuberculosis, Veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the I/DD population, and other prioritized members.~~

~~(3~~

(a) ~~MCEs shall make ICC services available to members identified with special health care needs or as priority populations including;~~Are older adults~~;~~, individuals who are ~~blind, deaf, or~~ hard of hearing, deaf, blind, or have other disabilities; ~~members with~~

(b) Have complex ~~medical needs,~~or high health care needs, or multiple or chronic conditions~~; those~~, or SPMI, or are receiving Medicaid-funded long-term care~~,~~ services~~,~~ and supports (LTCSS); ~~those who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting; individuals with behavioral health issues including chemical dependency or serious and persistent mental illness; children with serious emotional disturbance, children with Neonatal Abstinence Syndrome; those~~

(c) Are children ages 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems or have a SED diagnosis;

(d) Are in medication assisted treatment for ~~substance use disorder~~SUD;

(e) Are pregnant women, parents with dependent children, guardians of children, and ~~women with~~grandparents of dependent ~~children~~grandchildren;

(f) Are children with neonatal abstinence syndrome, children in Child Welfare;

(g) Are IV drug users, have SUD in need of withdrawal management; ~~individuals with~~

(h) Have HIV/AIDS~~; individuals with~~ or have tuberculosis;

(i) Are veterans and their families; and ~~individuals~~

(j) Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

(3) "Intensive Care Coordinator" (ICC Care Coordinator) means a person coordinating ICC services as defined in this rule.

(4) "Intensive Care Coordination Plan" (ICC Plan) means a collaborative, comprehensive, integrated and interdisciplinary-focused written document that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC Services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.

(5) All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children ~~and youth~~who are members of a prioritized population shall be provided ~~ICC and~~ behavioral health services according to presenting needs. ~~All other members shall be offered ICC services if qualified by screening and assessment.~~

~~(4) MCEs shall screen members for ICC eligibility. The initial health risk screening will include questions that indicate risk and need for sooner assessment of special/intensive health care needs.~~

~~(a) Screenings may take place upon referral of the member to the MCE for ICC services. The~~

(6) CCOs shall also conduct an ICC assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below in this section (6). All referrals for ICC assessments shall be responded to by the CCO within one business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening. ICC assessments shall be conducted when:

(a) A health risk screening conducted under, and in accordance with, OAR 410-141-3865 indicates a member has special health care needs or other needs or conditions that may indicate a need for ICC services;

(b) A member~~,~~ refers themselves;

(c) A member's representative~~, HCBS provider, provider, or other~~ or provider, including a home and community- based services provider, refers the member; or

(d) Upon referral of any medical personnel serving ~~the member or the~~as a member's ~~Medicaid~~ LTCSS case manager ~~may refer or self-refer the member for a health risk screening for ICC services. MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request. The MCE shall have an~~.

(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC needs. CCOs shall have established process for responding to ~~such~~all requests ~~and refer members~~ for ~~a health risk screening and assessment within 30 days when the member is~~

~~referred or is receiving Medicaid-funded LTCSS, or as quickly as the member's health condition requires~~ICC assessments or services, which shall include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one business day.

~~(b) MCEs shall~~

(8) ICC assessments shall identify the physical, behavioural, oral and social needs of a member.

(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (c)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility~~,~~ revise care plans ~~if necessary~~, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:

(a) For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan, and ensure care coordination ~~after notice of any~~efforts are undertaken in accordance with OAR 410-141-3865 and this rule. Contract shall be made with the member by the ICC care coordinator within three calendar days of receipt of notice of a reassessment triggering event;

(b) Reassessment triggering events include all of the following events ~~within 7 days, except that members already in ICC shall be contacted within 3 days~~:

(A) New hospital visit (ER or admission);

(B) New pregnancy diagnosis;

(C) New chronic disease diagnosis (includes behavioral health);

(D) New behavioral health diagnosis;

(E) Opioid drug use;

(F) IV drug use;

(G) Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);

(H) New I/DD diagnosis;

(I) Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;

(J) Recent homelessness;

(K) Two or more billable primary Z code diagnoses within ~~1~~one month;

(L) Two or more caregiver placements within past ~~6~~six months;

(M) An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;

(N) Discovery of new or ongoing behavioral health needs;

(O) Discharge from a residential setting or long-term care back to the community;

(P) Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;

(Q) Two or more readmissions to an acute care psychiatric hospital in a 6-month period;

(R) Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period; and

(S) Exit from ~~specialized~~condition-specific program.

(c) ~~Member rescreening~~Members shall be reassessed for ICC~~,~~ services and care ~~plan revision, must~~plans or, if applicable, ICC plans shall be ~~performed~~revised annually~~.~~;

(d) ~~Member rescreening~~Reassessment for ICC~~,~~ services and care ~~plan revision~~plans, or if applicable, ICC plans, revised if necessary, must be performed upon member request.

(~~5~~10) Members eligible for ICC shall be assigned ~~a~~an ICC care coordinator~~.~~;

(a) ICC Care coordinator assignments must be made within ~~3~~three business days~~.~~ of determining a member is eligible for ICC services;

(b) If a member is in a ~~specialized~~condition-specific program at the time they are determined eligible for ICC services, or enters a ~~specialized~~condition-specific program while receiving ICC services, then the ~~MCE~~CCO will appoint ~~that~~the care coordinator of the ~~specialized~~condition-specific program as the ICC care coordinator for the member while the member is in the ~~specialized~~condition-specific program. After ~~transition~~a member transitions from ~~the specialized~~a condition-specific program, the CCO must reassess the member for ICC services within ~~7~~seven calendar days of the transition and assign a new ICC care coordinator ~~in accordance with the provisions above.~~ within three business days of the completion of the ICC reassessment;

(c) ~~The MCE~~CCOs shall notify ~~the member~~members of their ICC status by at least two means of communication within ~~5~~five business days following the ~~screening~~completion of the ICC

assessment. Notifications shall include details ~~of~~about the ICC program and the name and contact information of ~~the~~their assigned ICC care coordinator.

(~~6~~11) ~~MCEs~~CCOs shall implement procedures to share the results of ~~screening~~ICC assessment including, without limitation, identifications ~~and treatment plans~~made as a result of the assessment and intensive care coordination plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member~~;~~, other parties identified in OAR 410-141-~~DDDD;~~3865 and, for members receiving ~~Medicaid funded~~ LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.679 and applicable state and federal privacy ~~requirements~~laws and meet timely access standards ~~defined~~set forth in in 410-141-3515.

~~(6) ICC activities include:~~

~~(a) Early identification of members eligible for~~12) ICC services~~;~~ shall include, without limitation:

(~~b~~a) Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;

(~~c~~b) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;

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

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

(~~8~~13) ICC Care coordinators ~~performing ICC~~ must ~~carry out~~provide the following services:

(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least once every ~~3~~three months and make other kinds of contact ~~of any kind~~ (face to face when possible) ~~3~~three times a month or more frequently if indicated. If an ICC care coordinator is unable to ~~do so~~comply with the member contact requirements, the ~~MCE~~CCO must document attempts made, barriers, and remediation efforts~~/plans~~ taken to overcome the barriers.~~
(b) Attempt~~ to the member contact requirements;

(b) Contact the member no more than ~~3~~three calendar days after receiving notification of a reassessment trigger described in ~~paragraph~~section (~~3~~9)~~(b) above~~ of this rule. If an ICC care coordinator is unable to make contact with the member within three calendar days of a

reassessment trigger, the ICC care coordinator must document in the member's case file all efforts made to contact the member. ICC care coordinators must continue brief contacts with members who have experienced a reassessment trigger as long as deemed necessary by the care team~~.~~ before they revert back to the routine contact requirements under subsection (a) of this section (13);

(c) Contact the member's Primary Care Provider (PCP) within ~~1~~one month of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care~~.~~;

(d) Facilitate communication between and among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;

(e) Convene and facilitate interdisciplinary team meetings monthly, or ~~sooner~~more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7)(d). The ICC care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:

~~(A)~~ (A) Describe the clinical interventions recommended to the treatment team;

~~(B)~~ (B) Create a space for the ~~Member~~member to provide feedback on their care, self-reported progress towards their ~~care~~ICC plan goals and their strengths exhibited in between current and prior meeting~~.~~;

(C) Identify coordination gaps and strategies to improve care coordination with the member's service providers;

(D) Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and

(E) Align with the member's individual ~~care~~ICC plan.

(f) Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings ~~and/~~or episodes of care.

(~~9~~12) If a member is enrolled in other programs, including condition-specific programs, where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager ~~supports~~shall be responsible for supporting specific needs based on their specialty within the interdisciplinary team.

(~~10~~13) ~~MCEs~~CCOs shall implement processes for ~~documentation~~documenting all of the ICC services provided and ~~the development of a treatment plan for a member identified with special health care needs~~attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. ~~MCEs~~CCOs shall produce ~~a treatment or service plan for members with special health care needs, including members receiving LTCSS that are determined through a health assessment to need a course of treatment or regular care monitoring~~ICC plans for each member requiring ICC services. Each ~~treatment~~ICC plan shall:

(a) Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTCSS providers and the member's participation;

(b) Include consultations with any specialist(s) caring for the member and DHS long-term services and supports providers and case managers;

(c) Be approved by the ~~MCE~~CCO in a timely manner if ~~MCE~~CCO approval is required;

(d) In alignment with rules outlined in OAR 410-141-3835 ~~MCE~~CCO Service Authorization; and

(e) In accordance with any applicable quality assurance and utilization review standards.

(~~11~~14) ~~MCEs~~CCOs shall periodically inform all participating providers of the availability of ICC and other support services available for members ~~and~~. CCOs shall also periodically provide training for patient-centered primary care homes and other primary care ~~providers'~~provider staff.

(~~12~~15) ~~MCE~~CCO staff ~~performing~~providing or managing ICC care coordination ~~shall meet the following requirements:~~
~~(a) ICC care coordinators~~services shall be required to:

(a) Be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the ~~MCE~~CCO's service areas who are identified as being of a prioritized population~~, aged, blind, or disabled or who have complex medical needs in all their service areas.~~;

(b) If a Member is unable to receive services ~~outside of~~during normal business hours, the ~~MCE~~CCO shall provide alternative availability options for the member~~.~~;

(~~b~~c) ~~Staff who coordinate or provide ICC services shall be~~Be trained for, and exhibit skills in, person-centered care planning and trauma informed care; and communication with and sensitivity to the ~~unique~~special health care needs of ~~people who are aged, blind, or disabled or who have complex medical needs~~priority populations. ~~MCEs~~CCOs shall have a written position description for ~~the~~its staff ~~member(s)~~ responsible for managing ICC services and for staff who provide ICC services~~.~~;

(~~c~~d) ~~MCEs~~CCOs shall have written policies that outline how the level of staffing dedicated to ICC is determined. ~~Policies may not permit more than 15 members in ICC per care coordinator. However, if~~

~~a member is in a specialized program, the MCE must follow the~~The ICC policies must include, without limitation, care coordination staffing standards ~~for~~such that ~~specialized group, if a lower ratio is called for~~the complexity, scope, and intensity of the needs of members receiving ICC services can be met.

(~~13~~16) Consistent with ~~OAR 410-141-3870~~the requirements under this rule, ~~MCEs~~CCOs shall make Integration and Care Coordination services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a Member is unable to receive services outside of normal business hours, the ~~MCE~~CCO shall provide alternative availability options for member.

(~~14~~17) ~~MCEs~~CCOs shall have a process to provide members ~~in ICC who have~~with special health care needs who are receiving ICC services with direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3875 MCE Grievances & Appeals: Definitions and General Requirements ~~(Revised 8/2/19)~~

(1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:

(a) "Appeal" means a review by an MCE, pursuant to OAR 410-141-3890 of an adverse benefit determination~~.~~;

(b) "Adverse Benefit Determination" means~~,~~ any of the following, consistent with 42 CFR § 438.400(b):

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(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 pursuant to 410-141-3515;

(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;

(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

(c) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860~~.~~;

(d) "Continuing benefits" means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910~~.~~;

(e) "Grievance" means a member's expression of dissatisfaction to the MCE or to ~~a participating provider~~the Authority about any matter other than an adverse benefit determination~~, as defined in OAR 410-120-0000~~. Grievances may 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 member's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision~~.~~;

(f) "Member." With respect to actions taken regarding grievances and appeals, references to a "member" include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to MCE notification requirements, a separate notice must be sent to each individual who falls within this definition.;

(g) "Notice of Adverse Benefit Determination" means the notice must meet all requirements found at 42 CFR 438.44 .

(2) MCEs shall establish and have an Authority approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:

(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;

(b) Member rights to appeal and request an MCE review of a notice of action/adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;

(c) Member rights to request a contested case hearing regarding an MCE notice of action/adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;

(d) An explanation of how MCEs shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;

(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;

(f) Specific to the appeals process, the policies shall:

(A) Consistent with confidentiality requirements, ensure the MCE's staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;

(B) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing.;

(C) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;

(D) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals.; and

(E) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.

(3) The MCE shall provide information to members regarding the following:

(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;

(b) Member rights and responsibilities; and

(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §§ 438.408(b)(1) and (2) and these rules.

(5) Upon receipt of a grievance or appeal, the MCE shall:

(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;

(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:

(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;

(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:

(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;

(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.

(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;

(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.

(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

(8) The following pertains to the release of a member's information:

(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.

(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.

(9) The MCE shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:

(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;

(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(10) The MCE, its subcontractors, and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

(11) In all MCE administrative offices and in those physical, behavioral, and oral health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) MCE appeal forms;

(c) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or

(d) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

(13) If at the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.

(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

Statutory/Other Authority: 413.032, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3880 Grievances & Appeals: Grievance Process Requirements ~~(Revised 8/2/19)~~

(1) A member and, with the written consent of the member, a provider or an authorized representative may file a grievance at any time either orally or in writing, on behalf of a member. The grievance may be filed with the MCE or the Authority. If the grievance is filed with the Authority, it shall be promptly forwarded to the MCE.

(2) For standard resolution of a grievance, the MCE shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. The MCE shall:

(a) Within five business days from the date of the MCEs receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or

(b) ~~Notify~~Promptly, but in no event more than five business days after the date of the MCE's receipt of the grievance, notify the member in their preferred language that there shall be a delay in the MCE's decision of up to 30 days. The written notice shall specify why the additional time is necessary.

(3) The MCE shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

(4) When informing members of the MCE's decision, the MCE:

(a) ~~Shall~~May provide its decision related to oral grievances ~~either~~ orally ~~or~~but shall also, in call instances respond to oral grievances in writing. Both oral and written responses shall be made in the member's preferred language;

(b) Shall address each aspect of the grievance and explain the reason for the decision; ~~and~~

(c) Shall respond in writing to written grievances in the member's preferred language. In addition to written responses, the MCE may also respond orally in the member's preferred language~~.~~; and

(d) ~~Notifies~~Shall notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the Authority's Ombudsperson.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, the MCE shall review and report to the Authority, as outlined in the CCO contract, member complaints related to their race and ethnicity, gender identity, sexual orientation, socioeconomic status, country of origin, and disability status.

(6) If an MCE receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another

MCE as defined in OAR 410-141-3850, the MCE shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3885 Grievances & Appeals: Notice of Action/Adverse Benefit Determination
~~**(Revised 8/2/19)**~~

(1) When an MCE has made an adverse benefit determination, the MCE shall notify the requesting provider and give the member and the member's representative a written notice of action/adverse benefit determination notice. The notice shall:

(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;

(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule;

(c) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:

(A) Date of the notice;

(B) MCE's name, address, and telephone number;

(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;

(D) Member's name, address, and member ID number;

(E) Service requested or previously provided and the adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment;

(F) Date of the service or date service was requested by the provider or member;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the adverse benefit determination if different from the date of the notice;

(I) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830;

(J) Clear and thorough explanation of the specific reasons for the adverse benefit determination;

(K) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;

(L) The member's or the provider's right to file an appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;

(M) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

(N) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;

(O) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and

(P) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination.

(d) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the Oregon's Notice of Action/Adverse Benefit Determination.

(2) The MCE shall provide copies of the following forms when the MCE issues a Notice of Adverse Benefit Determination:

(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or

(b) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(3) For requirements of notice of actions/adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least ~~ten~~10 days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.

(4) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following:

(a) The MCE may mail the notice no later than the date of adverse benefit determination if:

(A) The MCE has factual information confirming the death of the member;

(B) The MCE receives ~~a clear written statement signed~~notice that the services requested by the member ~~stating he~~are no longer ~~wishes services or gives~~desired or the MCE is provided with information that requires termination or reduction ~~of~~in services ~~and indicates that he understands that this must be the result of supplying that information;~~:

(i) All notices sent by a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;

(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.

(C) The MCE can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;

(D) The MCE is unaware of the member's whereabouts and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;

(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or

(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.

(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE:

(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and

(B) The MCE has verified those facts, whenever possible, through secondary resources.

(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.

(5) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.

Statutory/Other Authority: 414.032, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3890 Grievances & Appeals: Appeal Process ~~(Revised 8/2/19)~~

(1) A member, or a subcontractor or provider with the member's written consent, may file an appeal with the MCE to:

(a) Express disagreement with an adverse benefit determination; or

(b) Contest the MCE's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(2) Appeals may be initiated orally or in writing, subject to the following requirements:

~~(a)~~ (a) The MCE shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution~~.~~;

(b) ~~(b)~~ The MCE is considered to have satisfied this duty if the MCE has already made attempts to assist the member in filling out the necessary forms to file a written appeal.

(3) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.

(4) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal~~.~~;

(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing~~.~~;

(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.

(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.

(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:
(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;

~~(c)~~ (b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.

(7) Parties to the appeal include, as applicable:

(a) The MCE and the member; or

(b) The MCE and the member's provider.

(8) The MCE shall resolve each standard appeal in time period defined above in section (4). The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.

(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.

(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

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

(b) For appeals not resolved wholly in favor of the member:

(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 a contested hearing or expedited hearing with the Authority and how to do so;

(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and

(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;

(E) Copies of the appropriate forms:

(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or

(ii) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

Statutory/Other Authority: 413.032
Statutes/Other Implemented: 414.065

410-141-3895 Grievances & Appeals: Expedited Appeal ~~(Revised 8/2/19)~~

(1) Each MCE shall establish and maintain an expedited review process for appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860.

(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.

(3) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;

(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and

(c) Mail written confirmation of the resolution to the member within three days;

(d) Extend the timeframes by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.

(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(4) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.

(5) If the MCE denies a request for expedited resolution on appeal, the MCE shall:

(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;

(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.

[NOTE: Forms referenced are available from the agency.]

Statutory/Other Authority: 413.042 & 414.065
Statutes/Other Implemented: 414.065

410-141-3900 Grievances & Appeals: Contested Case Hearings

(1) An MCE shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing~~.~~:

(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings,

OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.;

(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule.;

(c) A provider that filed an appeal on the provider's own behalf for reasons set forth in OAR 410-120-1560 shall file a hearing request with the Authority no later than 30 days from the date of the MCE's notice of appeal resolution. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.

(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3), below.:

(a) The member shall file a hearing request with the Authority using form MSC 0443 or any other Authority-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905.;

(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's request.;

(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:

(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;

(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.

(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:

(A) Date-stamp the hearing request with the date of receipt; and

(B) Submit the following required documentation to the Authority within two business days:

(i) A copy of the hearing request notice of ~~action/~~adverse benefit determination, and notice of appeal resolution;

(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.

(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.

(~~4~~5) The parties to a contested case hearing include the following:

(a) The MCE and the member; or

(b) The MCE and the member's provider.

(~~5~~6) The Authority shall refer the hearing request along with the notice of ~~action/~~adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(~~6~~7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date the MCE receives the member's request for appeal. The 90-day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request.

(~~7~~8) For reversed appeal and hearing resolution services:

(a) For services not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

(b) For services furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member

received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3905 Grievances & Appeals: Expedited Contested Case Hearings

(1) An MCE shall have a system in place to ensure its members and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.

(3) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with the MCE, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.

(4) Expedited hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(5) The MCE shall submit relevant documentation to the Authority within two working days. The Authority shall decide within two working days from the date of receiving the relevant documentation whether the member is entitled to an expedited contested case hearing.

(6) If the Authority denies a request for an expedited contested case hearing, the Authority shall:

(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and

(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

(7) If a member requests an expedited hearing, the Authority shall request documentation from the MCE, and the MCE shall submit relevant documentation including clinical documentation to the Authority within two working days.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3910 Grievances & Appeals: Continuation of Benefits ~~(Revised 8/2/19)~~

(1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending~~.~~:

(a) To be entitled to continuing benefits, the member shall complete an MCE appeal request or an Authority contested case hearing request ~~for~~form and check the box requesting continuing benefits ~~before the sooner of~~by:

(A) The tenth day following the date of the notice of ~~action/~~adverse benefit determination or the notice of appeal resolution; or

(B) The effective date of the action proposed in the notice, if applicable~~, whichever is later~~.

(b) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;

(c) The benefits shall continue until:

(A) Unless the member requests a contested case hearing with continuing benefits, no later than ~~ten~~10 days following the date of the MCE notice of appeal resolution, a final appeal resolution resolves the MCE appeal;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for a hearing.

(2) For reversed appeal and hearing resolution services:

(a) Benefits not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

(b) Benefits furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the Authority shall pay for those services in accordance with the Authority policy and regulations.

Statutory/Other Authority: 413.032, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3915 Grievances & Appeals: System Recordkeeping

(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.

(2) MCE's must maintain yearly logs of all appeals and grievances for ~~ten~~10 years, which must include information about the reasons for each grievance or appeal, as well as the resolution and supporting reasoning.

(3) The MCE must review the log monthly for completeness, accuracy, and compliance with required procedures.

(4) ~~MCES~~MCE's shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.

(5) The Grievance System Report and Grievance and Appeals Log shall be forwarded to the MCE's Quality Improvement committee to comply with the Quality Improvement standards as follows:

(a) Review of completeness, accuracy, and timeliness of documentation;

(b) Compliance with written procedures for receipt, disposition, and documentation; and

(c) Compliance with applicable OHP rules.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610-414.685

410-141-3920 Transportation: NEMT General Requirements

(1) A CCO shall provide all non-emergency medical transportation (NEMT) services for its members. ~~In addition, the Authority shall provide NEMT services to clients within the CCO's service area who are not enrolled in a CCO.~~ For purposes of OAR 410-141-3920 to~~,~~ 410-141-3965, references to a "member" include any individual eligible for NEMT services under this section (1) unless context dictates otherwise.

(2) A CCO shall provide a toll-free call center for members to request rides.

(3) Neither a CCO nor any ~~contracted~~of its Subcontracted transportation ~~provider~~providers may bill a member for transport to or from covered medical services, even if the CCO or its contracted transportation provider denied reimbursement for the transportation services.

(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).

(5) A CCO shall have written policies and procedures ~~under which the individuals specified in section (1) may~~regarding its NEMT services. The CCO's policies and procedures shall be included in the CCO's Member Handbook, posted on the CCO's website, and included in the CCO's other general information materials. The CCO's written policies and procedures regarding NEMT services shall:

~~(a) Schedule~~

(a) Allow members or their representatives to schedule:

(A) NEMT services up to 90 days in advance;

(B) Multiple NEMT services at ~~least 24 hours~~one time for recurring appointments up to 90 days in advance; and

(~~b~~C) ~~Schedule same~~Same-day NEMT services.

(b) Not permit drivers to drop Members off at an appointment more than 15 minutes prior to the office or other facility opening for business; and

(c) Not permit drivers to pick up Members from an appointment more than 15 minutes after the office or facility closes for business; and

(d) Describe passenger rights and responsibilities including the right to file a grievance and request an appeal or reconsideration.

(6) The grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 are available with respect to NEMT services, with the following modifications:

(a) Prior to mailing a notice of ~~action~~adverse benefit determination to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.

(b) The CCO shall mail, within 72 hours of denial, a notice of ~~action~~adverse benefit determination to ~~a~~:

(A) A member denied a ride ~~within 72 hours of denial~~; and

(B) The provider or other third-party with which the affected member was scheduled for an appointment.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3925 Transportation: Vehicle Equipment and Driver Standards

(1) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

(2) The CCO shall require all vehicles used for NEMT services to meet the following requirements for the comfort and safety of the members:

(a) The interior of the vehicle shall be clean and free from any debris impeding a member's ability to ride comfortably;

(b) Smoking, aerosolizing or vaporizing of inhalants is prohibited in the vehicle at all times in accordance with ORS 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and

(c) ~~The transportation provider shall comply~~Compliance with ~~appropriate~~all applicable local, state, and federal transportation ~~safety standards~~laws regarding vehicle and passenger safety standards and comfort. ~~The vehicle~~All vehicles shall include, ~~but is not limited to~~without limitation, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) First aid kit;

(C) Fire extinguisher;

(D) Roadside reflective or warning devices;

(E) Flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to securely transport members using wheelchairs or stretchers~~, if~~ in accordance with the ~~member is using a wheelchair or stretcher~~Americans with Disabilities Act of 1990 (as amended) (ADA), Section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statute 659A.103.

(3) A preventative maintenance schedule shall be followed for each vehicle that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to, the following equipment:

(a) Side and rearview mirrors;

(b) Horn; and

(c) Working turn signals, headlights, taillights, and windshield wipers.

(4) Prior to hiring an NEMT driver, the CCO shall require the following:

(a) The driver must have a valid driver license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states;

(b) The driver shall not be included on the exclusion list maintained by the Office of the Inspector General; and

(~~b~~c) The driver must pass a criminal background check in accordance with ORS 181A.195 and 181A.200, and OAR chapter 257, division 10. If the driver is employed by a mass transit district formed under ORS Chapter 267, the driver must pass a criminal background check in accordance with ORS 267.237 as well as the mass transit district's background check policies. A CCO shall have an exception process to the criminal background check requirement that may allow approval of a driver with a criminal background under certain circumstances. The exception process must include review and consideration of when the crime occurred, the nature of the offense, and any other circumstances to ensure that the member is not at risk of harm from the driver. Any approvals made through the exception process must be documented and maintained for ~~three~~10 calendar years, even if the CCO is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three-year retention period.

(5) Drivers authorized to provide NEMT services must receive training on their job duties and responsibilities including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting, and the geographic area in which drivers will provide service;

(b) Completing the National Safety Council Defensive Driving course or equivalent within ~~six~~three months of the date of hire and at least every three years thereafter;

(c) Completing and maintaining certification for Red Cross-approved First Aid, Cardiopulmonary Resuscitation, and blood spill procedures courses or equivalent ~~within six months of the date of hire and maintain the certification~~prior to driving any members;

(d) Completing the Passenger Service and Safety course or equivalent course within ~~six~~three months of the date of hire and at least every three years thereafter; ~~and~~

(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride; and

(f) Understanding of and compliance with all state driving and transportation laws.

(6) Emergency Medical Technicians (EMT) licensed under OAR Chapter 333, Division 265 may be hired as an NEMT driver provided the CCO:

(a) Verifies the individual's EMT license is current, is in good standing with the Authority, and then re-verifies the license annually;

(b) Verifies the EMT is not on the exclusion list maintained by the Office of the Inspector General;

(c) Conducts its own criminal background check on the EMT in accordance with section (4)(c) of this rule; and

(d) Completes the training required under subsections (5)(a), (b) and (d) through (f).

(7) For authorized out-of-state NEMT services in which the transportation provider solely performs work in the other state and for which the CCO has no oversight authority, the CCO is not responsible for requiring that the subcontractor's vehicle and standards meet the requirements set forth in this rule.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3930 Transportation: Out-of-Service Area and Out-of-State Transportation

(1) A CCO shall provide NEMT services outside the CCO's service area under any and all of the following circumstances:

(a) The member is receiving ~~an OHP-~~covered ~~health care service~~services that ~~is~~are not available, in accordance with OAR 410-141-3515, in the CCO's service area ~~but is available in another area of the state~~;

(b) The member is receiving ~~an OHP~~ covered ~~service where~~services outside of Oregon, but the ~~service~~ location is contiguous to the CCO's service area and no more than 75 miles from the Oregon border ~~and is contiguous to the CCO's service area~~;

~~(c) The CCO determines that no local medical provider or facility as outlined in OAR 410-141-3515 will provide OHP-covered medical services for the member; or,~~

(c) The member is receiving in-patient services at a facility outside the CCO's service area due to unavailability within the CCO's service area and the member requires additional covered services within the service area where the inpatient service facility is located; and

(d) The member is receiving ~~an OHP~~ covered ~~service~~services outside the State of Oregon ~~that~~because the required covered service is not available ~~in~~within Oregon.

(2) Nothing in this rule prohibits a CCO from providing and paying for NEMT services to allow a client to access other services the CCO authorizes.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3935 Transportation: Attendants for Child and Special Needs Transports ~~(Revised 7/30/19)~~

(1) This rule applies to NEMT for children ~~under 15~~12 years of age and under who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to ~~children and young adults~~members with special physical or developmental needs regardless of age.

(2) Parents or guardians must provide an attendant to accompany these members while traveling to and from ~~medical appointments~~covered services and other purposes authorized by the CCO in accordance with OAR 410-141-3930(2) except when:

(a) The driver is a Department of Human Services (Department) volunteer or employee or an Authority employee;

(b) The member requires secured transport pursuant to OAR 410-141-~~3490~~3940 (Secured Transports); or

(c) An ambulance provider transports the member for non-emergent services, and the CCO reimburses the ambulance provider at the ambulance transport rate, per CCO contract or non-contracted rate policy.

(3) NEMT ambulance transports shall have an attendant when the CCO uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) The Department shall establish and administer written guidelines for members in the Department's custody including written guidelines for volunteer drivers. If the Department's requirements or administrative rules differ from this rule, the Department's requirements or administrative rules take precedence.

(5) An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant may also be any adult ~~the parent or guardian authorizes. An attendant may also be the member's brother, sister, stepbrother, or stepsister if the attendant is at least~~ 18 years ~~of age, and~~or older authorized by the member's parent or guardian ~~authorizes it~~.

(6) CCOs ~~may~~shall have the right to require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.

(7) ~~The~~Neither the CCO ~~may not~~nor its subcontractor shall bill additional charges for a member's attendant.

(8) The attendant must accompany the member from the pick-up location to the destination and the return trip. ~~The attendant must also remain with the member during their appointment.~~

(9) The member's parent, guardian, or adult caregiver shall provide and install safety seats as required by ORS 811.210–811.225. An NEMT driver may not transport a member if a parent or guardian fails to provide a safety seat that complies with state law.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625
410-141-3940 Transportation: Secured Transports

(1) "Secured transport" means NEMT services for the involuntary transport of members who are in danger of harming themselves or others. Secured transports may be used when:

(a) The CCO verified that the secured transporter has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and the secured transporter is able to transport the member who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the member in crisis.

(2) One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

(3) The CCO shall authorize transports to and from OHP covered medical services for an eligible member for court ordered medical services with the following exceptions:

(a) The member is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The member is an inmate of a public institution as defined in OAR 461-135-0950 (Eligibility for Inmates); or

(c) The Authority has suspended the member's OHP eligibility pursuant to ORS 411.439.

(4) The CCO shall assume that a member returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a member to their place of residence, the CCO shall obtain written documentation signed by the treating medical professional stating the circumstances that required secured transport. The CCO shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The CCO may approve and pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing if there is no other source of funding for this transport.

(6) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3945 Transportation: Ground and Air Ambulance Transports

(1) Transporting a member via ambulance is required when a medical facility or provider states the member's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the CCOs shall authorize the transport.

(3) CCOs shall provide ambulance transports with a medical technician when:

(a) A member's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The member does not have an attendant who can assist with personal care during the ride.

(4) When a member's medical condition is an emergency as defined in OAR 410-120-0000, emergency ambulance transportation must be used. The ambulance must transport the member to the nearest appropriate facility able to meet the member's medical needs.

(5) CCOs shall verify that ~~the Authority has licensed~~ providers of ground or air ambulance services have been licensed by the Authority to operate ground or air ambulances. If the ambulance service provider is located in a contiguous state and regularly provides rides to OHP members, the CCO must ensure ~~that~~the ambulance service provider has been licensed by both the Authority and the contiguous state ~~have licensed the ambulance service provider~~in which it is operating.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-~~3950~~3955 Transportation: Member Service Modifications ~~for Individuals with Disabilities~~and Rights

(1) For the purposes of this rule, "direct threat" means a significant risk to the health or safety of others~~. A direct threat is one that~~ and which:

(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes~~.~~; and

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence ~~that~~which shows:

(A) The nature, duration, and severity of the risk;

(B) The probability that a potential injury will actually occur; and

(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.

(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles which shall include, without limitation, policies and procedures that comply with this rule. CCOs shall provide its passenger safety policy and procedures to its NEMT subcontractors and require the NEMT subcontractors to implement and follow such policies and procedures. The CCOs' passenger safety policy and procedures shall be included in their member handbooks and posted on their websites.

(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.

(~~2~~4) ~~CCO's~~CCOs may not apply criteria, standards, or practices that screen out, or tend to screen out, individuals in a protected class, as defined under state anti-discrimination laws, from fully and equally enjoying any goods, services, programs, or activities unless:

(a) The criteria can be shown to be necessary for providing those goods and services; or

(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.

~~(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.~~

~~Statutory/Other Authority: ORS 413.042 & 414.625~~
~~Statutes/Other Implemented: ORS 414.625~~

~~**410-141-3955 Transportation: Service Modifications**~~

~~(1) CCOs shall draft policies and procedures describing passenger rights and responsibilities including the right to file a complaint and request reconsideration and provide this information in all general information materials such as handbooks.~~

~~(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles and provide the information to contractors, subcontractors, and members receiving NEMT services.~~

~~(3~~

(5) A CCO may modify ~~or a member may request modification of~~ NEMT services when the member:

(a) Threatens harm to the driver or others in the vehicle~~.~~;

(b) ~~Has a health condition that presents~~Presents a direct threat to the driver~~,~~ or others in the vehicle~~, or the member as described in OAR 410-141-3950~~.;

(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm~~.~~;

(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services~~.~~;

(e) Frequently does not show up for scheduled rides~~.~~; or

(f) Frequently cancels the ride on the day of the scheduled ride time.

~~(4~~

(6) A member may request modification of NEMT services when the NEMT driver:

(a) Threatens to harm the member or others in the vehicle;

(b) Drives or engages in other behavior that places the member or others in the vehicle at risk of harm; or

(c) Presents a direct threat to the member or others in the vehicle.

(7) Reasonable modifications include, but are not limited to, requiring members to:

(a) Use a specific transportation provider;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive or locate someone to drive the member and receive mileage reimbursement; and

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(~~5~~8) Members shall be advised at the time of request for NEMT services of the need for accommodation which shall be followed by written confirmation to the member, the member's care coordinator, and any requesting provider. Before modifying services, the NEMT provider, a CCO representative, and the member shall:

(a) Communicate about the reason for imposing a modification;

(b) Explore options that are appropriate to the member's needs; and

(c) Address health and safety concerns~~;~~.

(~~6~~9) The communications discussed in section (~~5~~8) of this rule may include:

(a) The member's care team, including any care coordinator, at the request or upon approval of the member or the CCO;

(b) Any ~~another~~other individual of the member's choosing.

(~~7~~10) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.

(~~8~~11) A CCO may not modify NEMT services under this rule ~~due solely to a request for~~unless the modification is permitted under this rule or required in order to accommodate a disability requiring modification or auxiliary aid ~~based on disability or other protected class status~~.
(~~9~~12) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.

(~~10~~13) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3960 Transportation: Member Reimbursed Mileage, Meals, and Lodging

(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.

(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.

(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. The OHP fee schedule is available on the Authority's website.

(4) The member must return any documentation a CCO requires before receiving reimbursement.

(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.

(6) A CCO shall reimburse members for meals when a member ~~travel~~travels:

(a) Out of their local area as outlined in OAR 410-141-3515(4)(a) and (b); and

(b) For a minimum of four hours round-trip.

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.

(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.

(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:

(a) The member is a minor child and unable to travel without an attendant;

(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;

(c) The member is mentally or physically unable to reach their medical appointment without assistance; or

(d) The member is or would be unable to return home without assistance after the treatment or service.
(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the ~~CCOs~~CCO's discretion.

(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The member; or

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;

(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.

(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3965 ~~Transportation:~~ Reports and Documentation ~~(Revised 8/2/19)~~

(1) CCOs shall maintain documentation of rides denied and rides provided to members.

(2) The CCO shall retain the documentation on NEMT service denials for ~~three~~10 calendar years, even if the CCO, its brokerage, or subcontractor that denied the service is no longer a Medicaid enrolled provider before the end of the ~~three~~10 years. The Authority may request this information at any time during the ~~three~~10-year retention period.

(3~~) For NEMT services denied to members, this documentation shall include:~~

~~(a) The name of the member and the individual requesting the ride on behalf of the member, if applicable;~~

~~(b) The member's OHP medical care identification number;~~

~~(c) The date and time of the request for transportation;~~

~~(d) The name of the employee who denied a ride;~~

~~(e) The name of the employee who performed the secondary review before denying the ride;~~

~~(f) The reason for the denial and the applicable OAR supporting the denial;~~

~~(g) The date on the notice of action the brokerage mailed to the member;~~

~~(h) Documentation on the review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and~~

~~(i) Notations of oral and written communications with the member.~~

~~(4~~) The Authority may request and the CCO shall provide other reports or information not specified in this rule.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

Summary of deletions:

Document comparison done by Workshare 10.0 on Thursday, October 24, 2019 1:03:10 PM

1	Page
2	**PAGE * Arabic * MERGEFORMAT**
3	of
4	**NUMPAGES * Arabic * MERGEFORMAT**
4	**2**
5	Table of
6	9
8	(Revised 8/2/19) 10
10	12
12	Accessibility 15
14	21
16	24
18	28
20	31
22	Substance Use Disorder
24	32
26	CCOs
28	33
30	Contact
32	35
34	39
36	(Revised 8/2/19) 41
38	48
40	52
42	55

44	57
46	64
48	68
50	69
52	70
54	71
56	73
58	74
60	75
62	76
64	77
66	78
68	79
70	80
72	81
74	82
76	87
78	95
80	100
82	102
84	105
86	106
88	111
90	115
92	116
94	Enrolment
96	118
98	124
100	133
102	(Revised 8/2/19) 136

104 (Revised 8/2/19) 140
106 142
108 (Revised 8/2/19) 143
110 148
112 151
114 155
116 (Revised 7/30/19) 158
118 162
120 168
122 172
124 (Revised 8/2/19) 178
126 (Revised 8/2/19) 184
128 185
130 (Revised 8/2/19) 185
131 (Revised 8/2/19) 188
133 (Revised 8/2/19) 191
135 193
137 196
139 (Revised 8/2/19) 197
141 198
143 199
145 200
147 202
149 (Revised 7/30/19) 203
151 204
153 205
155 410-141-3950 Transportation: Modifications for Individuals with Disabilities
206
157 207
159 209
161 Transportation:
162 (Revised 8/2/19) 211
166 (17
172 18
174 19
176 20
178 21
180 dental

22

23

24

or

Oregon Health Plan

25

receipt

26

27

state

28

29

30

31

especially one considered outside

mainstream

scientific medicine as

32

33

34

35

36

37

38

39

.

40

41

42

43

44) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments.

(45

46

47

together with

48

49

272 50
283 51
285 , as defined in OAR 410-120-0000
288 (52) (57
300 53
302 54
322
323 and it's
324 (a) Federal statutes and regulations;
325 (b) Waivers granted the Authority by
327 c
331 d
333 ,
334 provider
337 chapter
339 division
342 "Provider Rules")
344 (e
348 (
349)
350
351 **(Revised 8/2/19)**
353 .
356 .
358 A
360 state
362 i
364 ii
366 iii
368 state
370 B
375 state
377
378 CCOs
380 select providers using universal application
383 procedures and objective
385 information. CCOs shall take steps
388 .

390 CCOs
393 CCO
395 CCOs
397 .
399 CCOs
402 .
404 CCOs
406 CCOs
408 CCO
410 CCOs
412 CCO
414 a CCO
417 CCOs
419 OHP
421 CCOs
423 CCOs
425 CCOs
427 CCOs
429 A CCO
431 CCO
433 a CCO
435 a CCO
437 CCO
439 CCO
441 A CCO
443 4
445 5
447 CCO
449 CCO
451 4
453 6
458
459 **Accessibility**
461 (1)
466 for
468 (2)
470 (3)
472 specified

474 published by the Authority
476 MCEs
478 MCE
480 issues
482 MCEs
487 and
490 MCEs
492 sufficiently
494 issues
496 ;
499 (a)
500 .
502 (b)
505 MCEs
507 (a)
510 (A)
512 .
514 (B)
516 .
518 (b)
522 (A)
523 (B)
525 .
527 8
530 .
533 .
535 .
537 .
539 .
541 .
544 no more than 14 days later, and 4 appointments (including the second appointment) within 48 days
546 are
548 .
553 .
555 .
559 .
561 have a plan for ensuring

564 and shall monitor for compliance.
572 , an annual analysis of behavioral
575 , and an annual analysis of
578 contracted behavioral
581 workforce
583 .
585 Determining why appointments are not kept;
586 (ii)
588 (iii)
590 (iv)
592 Outreach services.
594 (c)
598 MCEs
600 and notify the Authority within 30 days of executing new contracts.
602 dental
604 MCEs
606 .
608 MCEs
610 .
612 (b)
614 ten
616 (i)
618 (ii)
620 iii
622 MCE
624 413.032
626
628 HI
630 ten
632 ten
634 ten
636 ten
638
641 in accordance with CFR 42 §438.332
642 specifically
643 are
647 implement
649 ongoing comprehensive quality assessment and performance improvement

program, QAPI

MCEMCE

requirements set for in CFR 42 §438.330,

and/

.

performance improvement

Projects must be designed to achieve significant improvement in health outcomes and enrollee satisfaction.

it collects

.

Quality Improvement

MCEs shall conduct

QAPI

QAPI

an assessment of annual activities conducted which includes a background and rationale for activities implemented; a plan of

improvement

to address gaps, which will ensure quality of care for MCE's members; and

MCEs shall submit the

to the Authority and, upon request by the Authority, the Authority's contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy requirements as outlined in MCE contract for the QAPI and transformational care annual evaluation criteria.

state

member's,

CCO

certification as a CCO or of

CCO

CCO

CCO

CCO

certification or of

CCO

CCO

CCO

a CCO

718 CCO
720 CCO
722 CCO
724 CCO
726 CCO
728 (a) Deductible or coinsurance amounts;
729 (b
731 CCO
734 c
736 CCO
738
739 **Substance Use Disorder**
741 Certain Behavioral Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP), or authorized Coordinated Care Organization (CCO).
742 (2) Substance Use Disorder (SUD)
744 .
746 The provision of SUD services shall comply
753 415, divisions 12, 20, and 50; OAR chapter 309, divisions 18, 19, and 22;
755 (b) Outpatient substance use disorder providers that are facilities or agencies shall have a certificate issued
757 415-012-0000 for the scope of services provided.
760 c
762 Any facility that meets
764 for substance-dependent persons
766 , or of a detoxification center as defined in ORS 430.306, shall be
771 -012-0000
773 .
775 (d) Detoxification centers shall have a license issued by the Authority as described in OAR 415-012-0000 and 415-050-0000 for the scope provided.
777 192.527, 192.528,
778 &
781 192.527, 192.528,
782 414010,
784 414.727
786
787 **CCOs**
789 a CCO
791 a CCO

793 CCO
795 CCO
797 CCO
799 .
801 a CCO.
803 CCO
805 a CCO
807 CCO
809 thirty
811 CCO
813 CCO
815 CCO
817 CCO
819 ten
821 CCO
823 CCO
825 CCO
827 CCO
829 ten
832 CCO
834 CCO
836 CCO
838 CCOs
840 CCOs
842 CCOs
844 CCO
846 CCO
848 ten
850 CCO
852 CCOs
854
855 **Contact**
857 ten
859 ten
861 ten
863 ;
865 ten
867 ten

HCE

ten

ten

(Revised 8/2/19)

;

.

.

.

(a)

.

(b)

.

(c)

.

(d)

;

must

must

.

services, whether they are

or other

.

,

must

must

.

must

must

must

14

must

.

must

must

948 .
950 .
952 .
954 .
956 .
958 .
960 .
963 a
965 b
967 .
969 communications with
971 .
973 A
975 .
977 (c) A process for appeals of the Authority’s edits or denials;
978 (d
980 e
982
989 Indian
995 .
997 honor
999 .
1001 AAAA SDOH/HE (4) (b)
1003
1004 MCE
1006 .
1008 .
1010 AAAA SDOH/HE (4) (b)
1013 .
1015 l
1017 Explanation
1020
1022 l
1024 l
1026
1027
1028 .
1030 .

(1)

(2)

(3)

.

a

l

(1)

a

.

b

.

c

(1)

a

.

b

.

.

.

.

.

.

the

.

.

.

5

.

.

(7) Dental care organizations: Each CCO shall have a contractual relationship with any DCO in its service area.

(8

.

.

9

10

11

12

dental

13

14

.

15

16

;

17

18

19

20

21

.

22

23

24

25

26

27

28

.

29

30

(1)

(2)

(3)

;

.

.

(B) These CAC representatives must not have any current or former relationship with the CCO, financial or otherwise, except as a Consumer Representative as defined in this rule. Impermissible relationships include employment or contractor relationships, either for the representatives themselves or for immediate family members.

at

thirty

fifteen

ten

thirty

,

sixty

sixty

(Revised 7/30/19)

(2

(a)

(b)

(c)

HE

Local public health authorities;

(e)

Hospitals;

(g)

(h)

(i)

(j)

(k)

(l)

;

3

analyze,

(A)

(B)

(C)

(D)

(E)

Identify programs that

including any treatment prevention and Early Intervention programs, and analyze the sufficiency and effectiveness of any such programs

Identify areas

Document the

(4

meaningful

living setting

or shared CHP priorities and strategies

(a)

(b)

(c)

HE

Local public health authority;

Hospitals

(f)

(g)

(h)

(i)

(m)

(j)

(k)

(a)

(A)

(B)

(C)

(D)

/HE

(E)

(b)

(A)

(B)

/HE

(C)

(D)

(E)

.

include a component for addressing the health of child and youth in the CCO service area. This must be developed

Early Learning Council, Early Learning Hubs, the Youth Development council and the school health providers in the region. This component addressing the

Include findings

and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan

Evaluate the

resources including school-based

centers

to meet the specific pediatric and adolescent health care needs in the community;

, including the addition or improvement of electronic medical records and billing systems

.

Take into consider whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;

(D)

(10

11

spending programs

and

The

pursuant to OAR [SB 1041 financial reporting rules under SAP]

(A)

(B)

(C)

(D)

(E)

(b

metric

measure

1375 c

1377 .

1379 (A

1383 . Social determinants of health fall into the following domains

1385 .

1387 B

1389 .

1391 (d) “SDOH-E Partner” means a community-based entity that delivers

1393 to address the social determinants of health and health equity; that

1395 Spending.

1398 e

1400 “

1401 Spending” means spending on services and

1402 designed to address SDOH-E. SDOH-E spending may consist of spending on health-related services, as that term is defined in OAR 410-141-3845 and OAR 410-141-3500. SDOH-E programs

1403 (A) Population health policy change, meaning changes to rules or procedures within a community or organization;

1404 (B) Systems change, meaning changes to infrastructure within a community or organization, and,

1405 (C) Services

1408 ’s’

1409 , meaning

1412 (f) “SDOH-E Spending Program” means a program overseen by the Authority with specific requirements for a CCO’s SDOHE Spending as set forth in the contract. SDOH-E spending programs include, but may not be limited to:

1413 (A)

1415 (B) Boosting Up Investment in Long-term Development for SDOH-HE Fund (BUILD Fund)

1416 (3

1446 general

1447 apply

1449 any SDOH-E spending program

1453 a

1455 based on

1459 .

1461 .

1463 b

1465 SDOH-E Spending Program expenditures

These contracts shall be submitted to the Authority for.

(4) The following requirements are specific to the SHARE Initiative:

.

(b) The portion of adjusted net income or reserves spent, as referenced above, shall equal or exceed the greater of:

(A) % of adjusted net income for the prior calendar year on a sliding scale based on Contractor's % Risk Based Capital (RBC) as of the end of that year (but prior to the SHARE portion calculation); or

(B) A proportion of the amount sent in dividends or payments or both to shareholders, parents, or other owners in that prior year.

(c) The Authority will provide the specifications for (A) and (B), including the sliding scale, as an initial reference document to CCOs by October 1, 2019, and publish any revisions for subsequent years by October 1st preceding a calendar year affected by such revision.

(d) The value of the %RBC floor, for the purposes of the sliding scale, will be the greater of:

(A) 250% RBC, or

(B) the percentage established in rule development for SB 1041 in relation to dividend payment restrictions.

(e) The Authority's discretion in adjusting net income shall be for the purpose of ensuring that CCOs do not distribute net income to stakeholders through other means than dividends (or similar payments to owners) to avoid SHARE Initiative spending. The Authority's discretion may also extend to relief from SHARE Initiative requirements in the event of net losses outside the CCO's reasonable control that would otherwise place the CCO's capital, surplus or reserves below 200% RBC.

(5) The following requirements are specific to the BUILD Fund:

(a) Dependent on availability of funds under the Medicaid growth cap, and within the Authority's budget at the discretion of its Director, the Authority may require that CCOs spend a fixed portion of their income on SDOH-E, in compliance with all SDOH-E Spending Program rules as set forth in this OAR, in the Contract between the CCO and the Authority, and in related guidance documents.

(6

.

SDOH-E Spending Programs

Interested

—

example, a member whose employer is up for consideration as an SDOH-E partner—shall recuse themselves from the decision-making process.

, as well as

align

1498 with
1500 membership
1501 demographic composition
1505 (8
1510 .
1514 a
1516 a
1518 address
1520 disparities that exist among the CCOs' members and, more generally, the communities within the CCOs' service areas
1522 .
1524 .
1526 (C) A plan for ensuring that the CCO's staff and provider network are trained on
1530 ,
1532 , and anti-discrimination laws, in accordance with the Authority's standards
1537 b
1541 .
1543 c
1546 for health equity with
1550 .
1555
1556 seeks to ensure
1559 to improve
1561 and
1563 services. THW is defined in OAR 410-180-0305
1565 .
1567 (B) Measurement standards and benchmarks;
1569 ; and
1571 recommendations
1573 standards issued by
1576 model
1577 defines
1579 THW payment levels and alternative
1580 The
1582 make this payment model grid
1584
1586 38050

1588 1

1590 .

1592 .

1594 2

1596 .

1598 .

1600 .

1602 3

1604 .

1606 .

1608 CAF

1610 enroll

1612 . Child Welfare

1614 .

1616 enroll

1618 .

1620 4

1623 .

1625 .

1627 .

1629 5

1631 3080

1633

1634 **Enrolment**

1636 -

1637 -

1638 .

1640 8

1642 9

1644 10

1646 11

1648 12

1650 .

1652 .

1654 (i)

1656 (ii)

1658 .

1660 13

.

shall enroll into the appropriate CCO for their service area.

(C) Other

include the following:

(A) Enrollment poses a serious health risk; and

(B) The Authority finds no reasonable alternatives

14

.

e

twelve

15

is assumed by

succeeding

.

succeeding

.

succeeding

16

.

If

must

,

In accordance with 42 CFR 438.56(c)(2), the

(applies to MAGI and non-Medicare APD members as defined by the Office of Client and Community Services Medical Programs OAR chapter 410 division 200).

during

, as defined in OAR 410-141-3805. The OHP eligibility period is typically 12 months

The plan change shall be considered “recipient choice.”

Once the recipient choice option has been applied, the member must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.

c

, if any of the following situations apply.

A

,

MCE

1734 B

1736 cesarean

1738 C

1740 MCE

1742 The effective date of disenrollment shall be the first of the month that the member’s Medicare Advantage plan disenrollment is effective.

1743 D

1746 (ii) The member

1747 Proof

1749 iii

1751 Continuity of care that is not in conflict with any section of OAR 410-141-3805, or as defined in this rule

1753 Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider.

1754 an OHP

1756 , including but not limited to a decision of a provider to participate or decline to participate in a MCE or a decision by the MCE to decline to contract with a provider;

1758 (d) Temporary enrolment

1766 .

1768 enrolment

1770 , as supported in 42 CFR 438.56(d)(2),

1772 MCE

1778 select and

1779 MCE plan

1782 e

1784 Member

1786 requests under this subsection (2) are subject to the following requirements.

1787 (A) The member

1789 MCE

1791 the

1794 ,

1796 the

1798 ,

1800 the

1802 42 CFR 438.56(c)(2), or there

1805 MCE

1807 (B) If 30

(a) Subject to applicable disability discrimination laws and subsection (4), the Authority may disenroll members for cause upon request by the MCE. Routine disenrollment for cause includes, but is not limited to, the following scenarios:

(A) The member commits

the member's

, consistent with 42 CFR 455.13

B) The member is uncooperative or disruptive, except where this is a result of the Member's special needs or disability.

(b) Routine

for reasons other than an uncooperative or disruptive member shall comply with the requirements of this subsection (b).

(A) The MCO

Coordinated Account Representative (CAR). The

and document that attempts at intervention were made as described below

(i) There shall be notification from the provider to the MCE at the time the problem is identified. The notification shall describe the problem and

. Such notification shall be documented in the member's clinical record. The MCE shall, as appropriate, conduct provider education or training regarding

services available to the provider;

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

(iii) The MCE shall provide

with the member in a serious effort to resolve the problem;

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

(v) If the severity of the problem warrants, the MCE shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their

. If necessary, the MCE shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(c) The MCE shall submit any additional information or assessments requested by the Authority CAR.

(d) The Authority shall notify the member in writing of any approved routine

disenrollment.

(e) Routine disenrollment for an uncooperative or disruptive member shall comply with the requirements of both subsection (b) and this subsection (c), unless the exception for expedited disenrollment applies as described below in subsection (d). If a member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence as the result of their special needs or disability, the MCE shall document each of the following:

A

A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses

to the health or safety of others. Direct threat

;

(B) A MCE-staffed

review

appropriate

in treating

condition to assess the

the

history of

;

(C) If warranted, a clinical assessment of whether the

will respond to

;

(D) Documentation of any

have been attempted and why the

haven't worked;

(E) Documentation of

this particular

or

;

(F

MCE

on their panel

shall

MCE

provider

MCE

MCE

The

shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(f)

by

MCE for

routine

process shall, to the extent feasible, comply with the

set forth above in subsection (c), and shall comply with the following requirements:

(A) In accordance with 42 CFR 438.56, the MCE shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have

's

referred to below as "the incident"). A

to others

The MCE

document the reasons for the request, provide written evidence

support

basis for the request, and document that attempts at intervention were made as described below.

(i) Providers shall

notify the MCE about the incident with the member

problem and shall be maintained for documentation purposes;

ii

The MCE

attempt, and

contact with

their

regarding

problem and, if needed,

in the resolution

;

(iii) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the MCE shall provide a written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined above. In making that determination, the MCE shall make an individualized assessment, based on reasonable judgment that

relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.

(iv) The MCE shall provide the following documentation:

(I) Documentation that verifies the provider or MCE immediately reported the incident to law enforcement. The MCE shall submit

signed

clinical

documenting the report to law enforcement or other reasonable evidence.

(II) Documentation that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others.

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

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

(B) The MCE shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;

(g) Approval or denial of routine disenrollment requests.

(A) If there is sufficient documentation, the request shall

CAR or a team of CARs who may request additional information from the Authority, the Authority's Ombudsperson, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Authority's substance use disorder specialist.

is also enrolled in the MCE

, the MCE shall provide proof to the Authority of CMS' approval to disenroll the member. If approved by the Authority, the date of disenrollment from both plans shall be the disenrollment date approved by CMS.

C

If

CAR

receipt what supporting documentation is needed for final consideration of the request.

(D) The CARs shall review the request and notify the MCE of the decision within ten working days of receipt of

from

MCE.

(E) Written decisions

2102 sent to

2104 MCE

2106 working

2108 from

2111 and sufficient documentation from the CAR

2113 (h) The following procedures apply to all approved disenrollment requests made by the MCE:

2114 (A) The CAR

2116 send

2119 a

2123 request was

2125 with a copy

2127 and

2131 notice shall give the disenrollment date, the

2132 , and the notice of

2135 complaint as specified in OAR 410-141-3875 through 410-141-3905

2137 to request an

2140 the option to continue enrollment in the MCE pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

2142 C

2146 date shall be

2148 is sent to the member

2149 the

2153 and ongoing enrollment pending a hearing decision. The

2157 the issuing of

2159 ’s decision to uphold disenrollment

2162 (i) If disenrollment is approved, the CAR shall contact the member’s care team to arrange enrollment in a different plan. The Authority may require the member to obtain services from FFS providers until such time as they can be enrolled with another MCE;

2163 (ii) If no other MCE is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. A member may not be involuntarily disenrolled from the same MCE for a period of more than 12 months. If, however, the member is re-enrolled after the 12-month period and the MCE or the member again requests disenrollment for cause, the request shall be referred to the Authority’s assessment team for review.

2164 (3) Other reasons for which an MCE may request disenrollment:

2165 (a) If the member is enrolled in the MCE on the same day the member is admitted to the hospital, the MCE

, as provided in 410-141-3805. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services.

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

(c

d) If the MCE

MCE shall report the TPL to the

and HIG send the MCE an email receipt, including a tracking number. The MCE

MCE A or B, effective the end of the month the TPL is reported, and the member is not reflected on that month's 834 report

.

(e) Members shall be disenrolled if out of

.

(f) The

.

(g) If, prior to Contract Year 2022 (or later if specified by the Authority), the member is in a state psychiatric institution;

(h

(4) The MCE may not disenroll members solely based on any of the following reasons:

(a) Because of a physical

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

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

(d) Because the member requests a hearing;

(e) Because the

f) Because of uncooperative

5) If a member's disenrollment request is denied, the MCE shall send the member a notice of action within 14 days after the decision for denial with a copy to the member, provider, and the member's care team; the notice shall include, pursuant to OAR 410-141-3875 through 410-141-3905, notice of the member's right to file a grievance or request a hearing. For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include:

(a) Involuntary transfer of a member from one MCE to another; or

(b) Automatic enrollment of a member in a MCE.

2218 disenrollment’s
2221 7
2225 in
2227 transferring
2229 take effect when
2231 contractual relationship ends
2233 a
2235 may
2237 8
2240 rule
2244 414.685
2247
2248) For purposes of this rule, the following definitions apply:
2249 (a)
2251 (b
2254 c
2258 2
2259 .
2261 .
2263 .
2265 3
2269 The individual is presumed to continue to be enrolled in the CCO
2273 which
2274 individual was most recently enrolled
2276 4
2278 5
2280 .
2282 6
2284 dental
2286 7
2288 8
2290 9
2292
2293 **(Revised 8/2/19)**
2294 paired with conditions
2296 specified by Statements of Intent or Guideline Notes which are included in
2298 funded portion
2301 service

dentally
410-141-3840.
.
.
integrate
.
and reasonable
services
covered if they appear
dentally
.
8
.
.
(C) Community standards; and
(D
.
.
diagnostic
providing assistance to
do
section,
’s
–
for
medical review unit may seek a coverage
from the Division
that
an MCE disagrees with the
dental
dental
dentally

(Revised 8/2/19)
the appropriate
Authorized
.
:

2402 or not
2403
2404 websitehttps
2406 CSI
2410 2019
2412 October
2414 2018
2416 &
2418 &
2420
2421 **(Revised 8/2/19)**
2422 MCES
2424 require
2428 actions/
2429 ten
2435 /
2437 .
2439 /
2442 ,
2444 in writing,
2448 ; and
2450 /
2454 .
2457
2458 dentally
2461 , when necessary, to request approval to treat members
2464 within ten calendar days of
2466 dental
2468 .
2471
2472 .
2474 .
2476 .
2480 42
2482 .
2484 .
2486 align
2488 . CCOs will align

2490 initiatives spending with any HRS CBI
2492 .
2495 .
2497 MCEs
2500 supplement
2501 .
2508 a
2511 ;
2512 (b)
2514 .
2515 (a)
2516 AAAA [new SDOH-HE rule].
2517 (b) Community benefit initiatives that are initiated by the CCO shall, for documentation purposes, be included in the CCOs' Transformation and Quality Strategy mid-year update and annual reports. Community benefit initiatives may not be documented in a treatment plan or clinical record
2519
2520 disenrolled from
2523 C
2527 .
2529 c
2531 sixty
2533 fragile children
2535 .
2537 .
2539)
2540 .
2542 .
2545 .
2548 21
2550 member's effective date with
2552 HIPAA compliant format to facilitate continued access to care.
2554 **(Revised 7/30/19)**
2555 sections
2557 13), (14), and (15
2559 client
2561 restrictive
2563 (PA). The restrictive drug list must align with the Fee-for-Service Preferred Drug List for any and all medications in drug classes required by OHA. Such

alignment must include:

(a) Identical preferred and non-preferred status; and

(b) Identical criteria for Prior Authorization for all medications on the PDL.

lists of all covered drugs on their

5

, the

must:

(a) Exist in a manner

Be

plan

an individual

the issuer

the member shall

of the

lists

6

7

eighteen

provider.

(8) MCEs shall provide their participating

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.

9

10

11

https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e

12

.

13

utilization

14

15

2627 ,
2628 .
2630 .
2632 .
2635 .
2637
2638 MCE
2640 MCEs
2643 MCEs
2645 MCEs
2647 MCE
2649 MCEs
2653 MCEs
2657 shall become
2658 MCEs shall develop
2660 the PCPCH
2662 where
2665 MCEs shall engage
2667 (d) CCOs shall administer the patient-centered primary care home program and receive program required reporting as supposed by OAR 409-055-0000 through 409-055-0090 and the CCO contract.
2668 an MCE
2673 MCE
2676 provide effective
2678 , coordination of care
2680 individuals
2682 a
2683 The MCE
2686 Demonstrate that
2688 MCE
2690 MCE
2694 MCEs shall develop
2697 are geographically located as close as possible to the member's residence
2700 MCEs
2703 are provided as close to the member's residence as possible.
2705 MCE
2707 shall be permitted
2708 an

that
participating as
of the MCE
may select an
enrollee
patient-centered primary care homes
MCEs
MCEs shall demonstrate how
shall
to achieve
. MCEs shall ensure
.
b
MCE
an MCE
MCE
MCE
.
c
The MCE shall implement
process
.
d
at the time of admission
a
MCE
MCE
appropriate
MCE
MCEs
MCE
MCE
MCEs
e
MCEs
MCE
MCEs
The MCE shall establish

2793 MCE
2795 MCEs shall develop a Memorandum of Understanding
2797 MOU
2799 contract
2801 , detailing
2804 MCEs shall establish agreements
2806 An MCE may
2808 not including substance use disorder treatment
2810 . (See
2812 for the definition of an IMD
2813)
2815 for
2817 service or
2818 , incorporating
2821 as defined
2824 For members
2826 As inpatient psychiatric
2829 stay
2831 inpatient psychiatric
2832 in an
2834 shall meet
2838 defined
2841 alternative service or setting
2843 MCE
2846 may
2848 a member
2851 MCE contract
2853 may be
2854 MCE
2856 the
2858 MCE
2860 An MCE
2862 demonstrate that
2864 MCE
2866 demonstrate ability to
2868 exchange
2871 MCE
2873 AAAA SDOH/HE (4)

2875 .
2876 (b) The MCE
2878 its
2880 MCEs
2882 MCEs
2884 MCEs
2886 that
2888 state hospital
2891 from
2893 MCEs
2897 MCE
2899 . MCE assignment is based on the case member's residence and referred to as county of origin or jurisdiction
2901 services
2904 out of
2906 MCE
2908 county of origin or jurisdiction
2911 out of area
2912 the MCE
2914 in the county of origin or jurisdiction,
2915 . For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3800 for program specific rules.
2916 (15)
2918 MCEs shall coordinate patient care, including care required by temporary residential placement outside the MCE service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon
2919 MCE enrollment
2921 be maintained in the county of origin with the expectation of the MCE
2925 the out of area placement and local providers;
2926 (b) The MCE shall coordinate the
2928 planning
2930 the county of origin.
2932 c
2934 16
2936 MCEs
2938 MCE
2940 MCE
2943 MCE
2945 17

2947 MCEs

2949 a

2950 crisis

2952 18

2954 MCEs

2956 309-035-0105

2958 19

2960 MCEs

2962 monitor the effectiveness of their integration and care coordination efforts. MCEs must

2963 1

2965 PCP-managed Care Coordination level and one at the

2966)

2967 20

2969 The MCE must report semiannually to the Authority on its

2972 MCE

2974 MCE

2976 The

2978 An identification

2981 (b

2984 MCE

2986 c

2990 (d

2996 for re-assessment exhibited within the reporting period;

2997 (e) Activity logs of Care Coordination services

2998 and

2999 .

3001 (21) The MCE must identify a

3006 This

3008 This

3010 MCE board and must be updated semiannually with

3013

3014 The CCO

3016 , not only those in ICC or specialized programs, through episodes of care, regardless of the physical location of the member

3017 The MCE

3021 .

3023 MCEs

3025 that assesses
3027 high-needs
3028 .
3030 the MCE
3032 and documented as quickly as
3034 requires, but at least within
3038 for all new members, or within
3042 referred or is receiving
3046 ,
3048 is
3050 for ICC,
3051 described
3060 , upon a change in responsibility,
3063 (d) MCEs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention, and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues, or when a member overutilizes services.
3064 (e) MCEs shall maintain documentation of
3068 completed
3070 . If
3072 MCE
3075 an
3077 MCE
3079 .
3081 (f) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document the screening in the member's record. An MCE
3084 its assessment,
3088 requirements
3091 Medicaid-funded
3092 3
3094 MCEs
3097 identify appropriate
3099 for referrals
3101 long-term services and supports
3103 4
3105 MCEs'
3107 MCEs
3109 intensive care coordination

3111 members
3113 Medicaid-funded
3114 5
3117 .
3119 .
3121 MCE Service Authorization.
3123 Be developed within 30 days and updated annually for all members not in ICC or a specialized program.
3124 specialized
3130 plan
3131 6
3133 shall
3135 .
3139 a
3143 shall participate
3144 .
3146 (b) Members must
3150 members and
3152 .
3154 a member’s
3156 a
3159 and denied access to
3164 the
3166 . The MCE
3169 exclusion
3171 have been
3174 exclusion must
3176 7
3178 The MCE
3181 8
3183 An MCE’s care
3185 must
3187) A care coordinator will:
3188 (A
3189 care
3191 B
3193 Set
3195 for the member

3196 C
3198 D
3200 E
3202 F
3204 G
3207 program
3209 b
3211 A
3213 Shall continue through episodes
3216 of individual
3217 B
3219 C
3222 D
3224 9
3226 An MCE
3228 must take the following steps to
3230 :
3232 The member’s care coordinator must participate and play
3234 specialized
3237 have
3240 2
3242 2
3244 . Care coordinators must attempt to engage
3248 face-to-face
3249 . The care coordinator shall also engage
3252 2
3255 within 1
3258 , 2
3261 a
3263 ,
3265 no
3267 2
3269 a
3271 , on a face-to-face basis if possible
3272 , CCOs will
3275 Contractor Service Area , 30 days prior to discharge,
3277 MCE
3279 fewer

.

The COO

and

region

f

The MCE must

and provide full oversight and supervision to the assigned care coordinators

such

must

This supervisory responsibility cannot be delegated or subcontracted outside of the CCO, and the CCO itself must hold

responsible for ensuring integrated coordination of care

410-141-3870

MCEs

intensive care coordination

herein

with SPMI, children

emotional or behavioral problems and/or have a SED diagnosis, individuals in medication assisted treatment for SUD, pregnant women and parents with dependent children,

, IV drug users, individuals with

, individuals with HIV/AIDS, individuals with tuberculosis, Veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the I/DD population, and other prioritized members.

(3

MCEs shall make ICC services available to members identified with special health care needs or as priority populations including;

;

blind, deaf, or

members with

medical needs,

; those

,

,

those who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting; individuals with behavioral health issues including chemical dependency or serious and persistent mental illness; children with serious emotional disturbance, children with Neonatal Abstinence Syndrome; those

3351 substance use disorder

3355 women with

3357 children

3365 individuals with

3367 ; individuals with

3370 individuals

3376 and youth

3378 ICC and

3379 All other members shall be offered ICC services if qualified by screening and assessment.

3380 (4) MCEs shall screen members for ICC eligibility. The initial health risk screening will include questions that indicate risk and need for sooner assessment of special/intensive health care needs.

3381 (a) Screenings may take place upon referral of the member to the MCE for ICC services. The

3385 ,

3388 , HCBS provider, provider, or other

3391 the member or the

3393 Medicaid

3394 may refer or self-refer the member for a health risk screening for ICC services. MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request. The MCE shall have an

3397 such

3399 and refer members

3400 a health risk screening and assessment within 30 days when the member is referred or is receiving Medicaid-funded LTCSS, or as quickly as the member's health condition requires

3402 (b) MCEs shall

3405 ,

3406 if necessary

3409 after notice of any

3412 within 7 days, except that members already in ICC shall be contacted within 3 days

3413 1

3415 6

3417 specialized

3419 Member rescreening

3423 ,

3425 plan revision, must

performed
.
Member rescreening
,
plan revision
5
a
.
3
.
specialized
specialized
MCE
that
specialized
specialized
transition
the specialized
7
in accordance with the provisions above.
The MCE
the member
5
screening
of
the
6
MCEs
screening
and treatment plans
;
DDDD;
Medicaid-funded
requirements
defined
6) ICC activities include:
(a) Early identification of members eligible for
;

3512 b

3514 c

3516 d

3518 e

3520 8

3523 performing ICC

3524 carry out

3527 3

3530 of any kind

3531 3

3534 do so

3536 MCE

3539 /plans

3542 .

3543 (b) Attempt

3547 3

3549 paragraph

3551 3

3553 (b) above

3556 .

3560 1

3563 .

3565 sooner

3568 (A)

3570 (B)

3572 Member

3574 care

3576 .

3578 care

3580 and/

3581 9

3584 supports

3586 10

3588 MCEs

3590 documentation

3594 the development of a treatment plan for a member identified with special health care needs

3596 MCEs

a treatment or service plan for members with special health care needs, including members receiving LTCSS that are determined through a health assessment to need a course of treatment or regular care monitoring

treatment

MCE

MCE

MCE

11

MCEs

and

providers'

12

MCE

performing

shall meet the following requirements:

(a) ICC care coordinators

MCE

, aged, blind, or disabled or who have complex medical needs in all their service areas.

outside of

MCE

.

b

Staff who coordinate or provide ICC services shall be

unique

people who are aged, blind, or disabled or who have complex medical needs

MCEs

the

member(s)

.

c

MCEs

Policies may not permit more than 15 members in ICC per care coordinator. However, if a member is in a specialized program, the MCE must follow the

for

specialized group, if a lower ratio is called for

13

OAR 410-141-3870

MCEs

3672 MCE
3674 14
3676 MCEs
3678 in ICC who have
3681
3682 **(Revised 8/2/19)**
3683 .
3685 ,
3686 .
3688 .
3690 a participating provider
3692 , as defined in OAR 410-120-0000
3695 .
3697 .
3700 :
3702 .
3704
3705 **(Revised 8/2/19)**
3706 Notify
3708 Shall
3710 either
3711 or
3714 and
3715 .
3717 Notifies
3719 **(Revised 8/2/19)**
3720 ten
3722 a clear written statement signed
3724 stating he
3726 wishes services or gives
3728 of
3730 and indicates that he understands that this must be the result of supplying that information;
3734
3735 **(Revised 8/2/19)**
3736 (a)
3738 .
3741 (b)

.

.

(c)

(Revised 8/2/19)

.

.

.

A provider that filed an appeal on the provider's own behalf for reasons set forth in OAR 410-120-1560 shall file a hearing request with the Authority no later than 30 days from the date of the MCE's notice of appeal resolution.

.

.

.

action/

4

5

action/

6

7

(Revised 8/2/19)

.

for

before the sooner of

action/

, whichever is later

ten

ten

MCES

In addition, the Authority shall provide NEMT services to clients within the CCO's service area who are not enrolled in a CCO.

,

contracted

provider

3802 under which the individuals specified in section (1) may
3806 (a) Schedule
3810 least 24 hours
3812 b
3814 Schedule same
3819 action
3824 action
3826 a
3832
3833 The transportation provider shall comply
3835 appropriate
3837 safety standards
3841 The vehicle
3843 but is not limited to
3846 , if
3848 member is using a wheelchair or stretcher
3851 b
3853 three
3855 six
3858 within six months of the date of hire and maintain the certification
3860 six
3862 and
3872 an OHP-
3873 health care service
3875 is
3879 but is available in another area of the state
3880 an OHP-
3881 service where
3883 service
3886 and is
3888 (c) The CCO determines that no local medical provider or facility as outlined in OAR 410-141-3515 will provide OHP-covered medical services for the member; or,
3890 an OHP-
3891 service
3894 that
3896 in
3898

3899 **(Revised 7/30/19)**

3900 under 15

3903 children and young adults

3905 medical appointments

3907 3490

3909 the parent or guardian authorizes. An attendant may also be the member's brother, sister, stepbrother, or stepsister if the attendant is at least

3910 of age, and

3913 authorizes it

3914 may

3916 The

3918 may not

3920 The attendant must also remain with the member during their appointment.

3921 the Authority has licensed

3923 that

3926 have licensed

3929

3930 **3950**

3933 **for Individuals with Disabilities**

3935 . A direct threat is one that

3937 .

3939 that

3944 2

3946 CCO's

3952 & 414.625

3954 414.625

3955

3956 **410-141-3955 Transportation: Service Modifications**

3957 (1) CCOs shall draft policies and procedures describing passenger rights and responsibilities including the right to file a complaint and request reconsideration and provide this information in all

3959 such as handbooks.

3961 and provide the information to contractors, subcontractors, and members receiving NEMT services.

3962 (3

3964 or a member may request modification of

3965 .

3967 Has a health condition that presents

3969 ,

3971 , or the member as described in OAR 410-141-3950.

3973 .

3975 .

3977 .

3979 (4

3990 5

3994 ;

3996 6

3998 5

4003 another

4005 7

4007 8

4009 due solely to a request for

4011 based on disability or other protected class status

4012 9

4014 10

4016

4017 travel

4019 CCOs

4021

4022 **Transportation:**

4023 **(Revised 8/2/19)**

4024 three

4026 three

4028 three

4030) For NEMT services denied to members, this documentation shall include:

4031 (a) The name of the member and the individual requesting the ride on behalf of the member, if applicable;

4032 (b) The member's OHP medical care identification number;

4033 (c) The date and time of the request for transportation;

4034 (d) The name of the employee who denied a ride;

4035 (e) The name of the employee who performed the secondary review before denying the ride;

4036 (f) The reason for the denial and the applicable OAR supporting the denial;

4037 (g) The date on the notice of action the brokerage mailed to the member;

4038 (h) Documentation on the review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

4039 (i) Notations of oral and written communications with the member.

4040 (4

Document comparison by Workshare 10.0 on Thursday, October 24, 2019 1:03:11 PM

Input:	
Document 1 ID	file://C:\Users\etaus\Workshare\Folders\Inbox\1 Single Document CLEAN with TOC 080219.docx
Description	1 Single Document CLEAN with TOC 080219
Document 2 ID	file://C:\Users\etaus\Workshare\Folders\Inbox\## 410-141-3500 - 410-141-3965 Final filed version returned with TOC.docx
Description	## 410-141-3500 - 410-141-3965 Final filed version returned with TOC
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Redline Summary:		
No.	**Change**	**Text**
1-4	Deletion	~~Page 1 of 2~~
5	Deletion	~~Table of~~ Contents
6-7	Change	System Regulation; Rule Precedence ~~9~~13
8-9	Change	410-141-3505 Use of Subcontractors ~~(Revised 8/2/19) 10~~ 14

10-11	Change	Provider Contracting and Credentialing ~~12~~16
12-13	Change	410-141-3515 ~~Accessibility15~~Network Adequacy 20
14-15	Change	of Health Information Technology ~~21~~26
16-17	Change	410-141-3525 Outcome and Quality Measures ~~24~~29
18-19	Change	410-141-3530 Sanctions ~~28~~33
20-21	Change	410-141-3540 Member Protections ~~31~~36
22-23	Change	410-141-3545 Coordinated Care Organization ~~Substance Use Disorder~~Behavioral Health Provider, Treatment and Facility
24-25	Change	Facility Certification and Licensure ~~32~~37
26-27	Change	410-141-3550 Resolving Disputes between ~~CCOs~~MCEs and the Authority
28-29	Change	and the Authority ~~33~~38
30-31	Change	Entities and CCOs that Concern CCO ~~Contact~~Contract Award
32-33	Change	Award ~~35~~40
34-35	Change	Between Health Care Entities and CCOs ~~39~~44
36-37	Change	410-141-3565 Managed Care Entity Billing ~~(Revised 8/2/19)~~ ~~41~~ 46
38-39	Change	Encounter Claims Data Reporting~~48~~53
40-41	Change	MCE Member Relations: Marketing ~~52~~57
42-43	Change	Relations: Potential Member Information ~~55~~60
44-45	Change	Relations: Education and Information ~~57~~62
46-47	Change	Member Rights and Responsibilities ~~64~~69
48-49	Change	410-141-3600 MCE Assessment: Definitions ~~68~~73

50-51	Change	Assessment: General Administration ~~69~~74
52-53	Change	Assessment: Disclosure of Information ~~70~~75
54-55	Change	Report, Due Date, Verification ~~71~~76
56-57	Change	Assessment: Filing an Amended Report ~~73~~78
58-59	Change	Assessment: Determining the Date Filed~~74~~79
60-61	Change	Assessment: Authority to Audit Records ~~75~~80
62-63	Change	Assessment Liability on Failure to File ~~76~~81
64-65	Change	Failure to Pay Assessment When Due ~~77~~82
66-67	Change	Assessment: Notice of Proposed Action ~~78~~83
68-69	Change	MCE Assessment: Hearing Process ~~79~~84
70-71	Change	Assessment: Final Order of Payment ~~80~~85
72-73	Change	Available after Final Order of Payment ~~81~~86
74-75	Change	Application and Contracting Procedures ~~82~~87
76-77	Change	410-141-3705 Criteria for CCOs ~~87~~92
78-79	Change	Termination and Close-Out Requirements ~~95~~100
80-81	Change	Public Meetings and Transparency ~~100~~105
82-83	Change	Service Area Change for Existing CCOs ~~102~~107
84-85	Change	CCO Contract Renewal Notification ~~105~~110
86-87	Change	Community Health Improvement Plans ~~106~~111
88-89	Change	Health and Equity; Health Equity ~~111~~115
90-91	Change	410-141-3740 Traditional Health Workers ~~115~~120
92-93	Change	Children Receiving Health Services

		~~116~~121
94-95	Change	410-141-3805 Mandatory MCE ~~Enrolment~~Enrollment Exceptions
96-97	Change	Exceptions ~~118~~123
98-99	Change	410-141-3810 Disenrollment from MCEs ~~124~~129
100-101	Change	Behavioral Health Treatment Services ~~133~~140
102-103	Change	410-141-3820 Covered Services ~~(Revised 8/2/19)~~ ~~136~~ 142
104-105	Change	Excluded Services and Limitations ~~(Revised 8/2/19)~~ ~~140~~ 147
106-107	Change	Prioritized List of Health Services ~~142~~149
108-109	Change	410-141-3835 MCE Service Authorization ~~(Revised 8/2/19)~~ ~~143~~ 150
110-111	Change	Emergency and Urgent Care Services ~~148~~155
112-113	Change	410-141-3845 Health-Related Services ~~151~~158
114-115	Change	410-141-3850 Transition of Care ~~155~~162
116-117	Change	410-141-3855 Preferred Drug List ~~(Revised 7/30/19)~~ ~~158~~ 166
118-119	Change	Integration and Coordination of Care ~~162~~169
120-121	Change	Care Coordination Requirements ~~168~~175
122-123	Change	410-141-3870 Intensive Care Coordination ~~172~~180
124-125	Change	Definitions and General Requirements ~~(Revised 8/2/19)~~ ~~178~~ 187
126-127	Change	Appeals: Grievance Process Requirements ~~(Revised 8/2/19)~~ ~~184~~ 192
128-129	Change	Action/Adverse Benefit Determination ~~185~~194
130	Deletion	~~(Revised 8/2/19)~~ ~~185~~
131-132	Change	Grievances & Appeals: Appeal Process ~~(Revised 8/2/19)~~ ~~188~~ 197
133-134	Change	Grievances & Appeals: Expedited Appeal

		~~(Revised 8/2/19) 191~~ 200
135-136	Change	Appeals: Contested Case Hearings ~~193~~202
137-138	Change	Expedited Contested Case Hearings ~~196~~205
139-140	Change	Appeals: Continuation of Benefits ~~(Revised 8/2/19) 197~~ 206
141-142	Change	& Appeals: System Recordkeeping ~~198~~207
143-144	Change	Transportation: NEMT General Requirements ~~199~~208
145-146	Change	Equipment and Driver Standards ~~200~~210
147-148	Change	and Out-of-State Transportation ~~202~~213
149-150	Change	Child and Special Needs Transports ~~(Revised 7/30/19) 203~~ 214
151-152	Change	Transportation: Secured Transports ~~204~~215
153-154	Change	Ground and Air Ambulance Transports ~~205~~216
155	Deletion	~~410-141-3950...with Disabilities 206~~
156	Insertion	410-141-3955 Transportation: Member Service Modifications
157-158	Change	Service Modifications ~~207~~ and Rights 217
159-160	Change	Reimbursed Mileage, Meals, and Lodging ~~209~~220
161	Deletion	410-141-3965 ~~Transportation:~~ Reports and Documentation
162-163	Change	Reports and Documentation ~~(Revised 8/2/19) 211~~ 222
164	Insertion	means the division in the Department of Human Services (Department) that administers programs for seniors
165	Insertion	community consistent with ORS 414.625. CCOs shall afford an...on CACs as follows:
166	Deletion	~~(17~~
167	Insertion	(a) In CCO service areas...to serve on the CAC;
168	Insertion	(b) In CCO service areas...within the service

		area;
169	Insertion	(c) In metropolitan CCO...to serve on the CAC.
170	Insertion	(17) “Community Benefit...health care quality.
171	Insertion	(18) “Contract” means an agreement
172-173	Change	(~~18~~19) “Coordinated Care Organization
174-175	Change	(~~19~~20) “Coordinated Care Services” mean
176-177	Change	(~~20~~21) “Corrective Action” or “Corrective
178-179	Change	(~~21~~22) “Dental Care Organization (DCO)”
180-181	Change	MCE that provides and coordinates ~~dental~~oral health services as capitated services
182-183	Change	(~~22~~23) “The Department” means the Department
184-185	Change	(~~23~~24) “Department of Consumer and Business
186-187	Change	(~~24~~25) “Disenrollment” means the act
188-189	Change	member from enrollment with an MCE ~~or~~.
190	Insertion	(26) "Diversity of the
191-192	Change	the ~~Oregon Health Plan~~Workforce" refers to the...delivery of health care.
193-194	Change	(~~25~~27) “Enrollment” means the assignment
195-196	Change	member to an MCE for management and ~~receipt~~coordination of health services.
197-198	Change	(~~26~~28) “Family Planning”...services include:
199	Insertion	(a) Annual exams;
200	Insertion	(b) Contraceptive...health issues;
201	Insertion	(c) Prescription...patches or rings);
202	Insertion	(d) IUDs and implantable...insert and remove them;
203	Insertion	(e) Injectable hormonal...(such as Depo-Provera);
204	Insertion	(f) Prescribed...caps, and foams);
205	Insertion	(g) Laboratory tests...and cancer screening;
206	Insertion	(h) Radiology services;
207	Insertion	(i) Medical and surgical...ligations and abortions.
208	Insertion	(29) “Flexible Services”...to covered benefits.

209	Insertion	(30) “Global Budget” means the total
210-211	Change	(~~27~~31) “Grievance System” means the overall
212-213	Change	Contested case hearings through the ~~state~~Authority on adverse benefit determinations
214-215	Change	(~~28~~32) “Health Literacy” means the degree
216-217	Change	(~~29~~33) “Health-Related Services” means
218-219	Change	(~~30~~34) “Health System Transformation”
220-221	Change	(~~31~~35) “Holistic Care” means incorporating
222-223	Change	holism in a system of therapeutics, ~~especially one considered outside~~such as the
224-225	Change	the ~~mainstream~~practices of
226	Deletion	of ~~scientific medicine as~~ naturopathy or chiropractic and
227-228	Change	(~~32~~36)
229	Moved to	“Home CCO” means the CCO...on permanent residency.
230	Insertion	(37) “Indian” means an American Indian
231-232	Change	(~~33~~38) “Indian Health Care Provider (IHCP)”
233-234	Change	(~~34~~39) “Individual with...or understand English.
235	Insertion	(40) “Institution for Mental Diseases
236-237	Change	(~~35~~41) “Intensive Care Coordination”
238-239	Change	(~~36~~42) “Legal Holiday” means the days
240-241	Change	(~~37~~43) “Licensed Health Entity” means
242-243	Change	(~~38~~44) “Managed Care Entity (MCE)” means,
244	Insertion	entity that enters into a contract with the Authority to provide services in a managed
245-246	Change	(~~39~~45) “Medicaid-Funded Long-Term Care,
247-248	Change	including state psychiatric hospitals~~.~~;
249-250	Change	(~~40~~46) “Member” means an OHP client enrolled
251-252	Change	(~~41~~47) “Member Representative” means
253-254	Change	(~~42~~48) “Mental Health Organization (MHO)”
255-256	Change	(~~43~~49) “National Association of Insurance
257	Deletion	~~(44) “Net Premium” means...HRA and GME payments.~~

258-259	Change	~~(45~~50) “Non-Participating Provider” means
260-261	Change	(~~46~~51) “Ombudsperson Services” means
262-263	Change	(~~47~~52) “Oral Health” means...the scope of practice.
264	Insertion	(53) “Oregon Health Plan (OHP)” means
265-266	Change	s Medicaid program ~~together with~~or related state-funded health programs.
267	Insertion	related state-funded health programs. Any OHP contract shall...health program, or both.
268-269	Change	(~~48~~54) “Oregon Integrated and Coordinated
270-271	Change	(~~49~~55) “Participating Provider” means
272-273	Change	(~~50~~56) “Participating...on the MCE’s panel and;
274	Insertion	(a) An employer of a...to the employer; or
275	Insertion	(b) The facility in which...submits claims; or
276	Insertion	(c) A foundation, plan,...submits the claim;
277	Insertion	(d) Such group practice,...or organization; and
278	Insertion	(e) An agent if such...made to each provider.
279	Insertion	(57
280	Moved to	) “Permanent Residency”...to after placement ends.
281	Moved to	(
282	Insertion	58) “Potential Member” means an individual
283-284	Change	(~~51~~59) “Primary Care Provider (PCP)”
285	Deletion	practice for identified clients~~, as defined in OAR 410-120-0000~~. PCPs
286	Insertion	. PCPs are health professionals who initiate referrals for care outside
287	Insertion	medically appropriate client care. PCPs include:
288	Deletion	~~(52) (57~~
289	Insertion	(a) The following...area of primary care;
290	Insertion	(b) A health care team or...and OAR 410-120-0000.
291	Insertion	(60) “Provider” means,...facility, institution,
292	Insertion	corporate entity, or...otherwise specified.

293	Insertion	(61) “Provider...organization that is:
294	Insertion	(a) An employer of a...to the employer; or
295	Insertion	(b) The facility in which...submits claims; or
296	Insertion	(c) A foundation, plan,...submits the claim;
297	Insertion	(d) Such group practice,...or organization; and
298	Insertion	(e) An agent if such...made to each provider.
299	Insertion	(62) “Readily Accessible” means electronic
300-301	Change	(~~53~~63) “Service Area” means the geographic
302-303	Change	(~~54~~64) “Serious Emotional...the following criteria:
304	Insertion	(a) A child or youth,...to 21 years of age; and
305	Insertion	(b) Must meet criteria...impairment and duration:
306	Insertion	(A) Diagnosis: The child...or mental disorder):
307	Insertion	(i) For children 3 years...subsequent revisions);
308	Insertion	(ii) For children 4 years...or mental disorder).
309	Insertion	(B) Functional...the family, school or
310	Insertion	community, or in a...or primary health care;
311	Insertion	(C) Duration: The...last more than 1 year.
312	Insertion	(65) “Trauma Informed...respective entities.
313	Insertion	(66
314	Moved to	) “Temporary Placement” means
315	Insertion	, for purposes of this rule,
316	Moved to	hospital, institutional,...Home CCO service area.
317	Moved to	(
318	Insertion	67) "Trauma-informed...Informed Approach.
319	Insertion	(68) “Treatment Plan” means a documented
320	Insertion	(69) “Urban Indian Health...1653 of Title 25.
321	Insertion	(70) "Workforce diversity...organizational capacity.
322	Deletion	410-141-3501 Administration of Oregon
323	Deletion	(1) The Authority ~~and it's~~ may adopt reasonable and lawful
324	Deletion	~~(a) Federal statutes and regulations;~~

325	Deletion	~~(b) Waivers granted the Authority by~~
326	Insertion	(a) Medicaid Plan and...or other directives from CMS;
327-328	Change	(~~c~~b) Federal Statutes;
329	Insertion	(c) Federal Regulations;
330	Insertion	(d) Oregon Revised Statutes;
331-332	Change	(~~d~~e) Oregon Administrative Rules
333	Deletion	) Oregon Administrative Rules~~,~~ using the following order of precedence:
334-335	Change	(C) Any applicable ~~provider~~Provider rules
336	Insertion	rules in OAR 410 based on the category of health
337-338	Change	(D) OAR ~~chapter~~Chapter 943
339-340	Change	943 ~~division~~, Division 120
341	Insertion	120 ;
342-343	Change	(~~"Provider Rules")~~E) OAR Chapter 309;
344	Deletion	~~(e~~
345	Insertion	(F) All other applicable OARs;
346	Insertion	(f) The MCE Contract
347	Insertion	) The MCE Contract,
348	Deletion	~~(~~including any internal order of
349	Deletion	of precedence established therein~~)~~.
350	Deletion	410-141-3505 Use of Subcontractors
351	Deletion	410-141-3505 Use of Subcontractors ~~(Revised 8/2/19)~~
352	Moved from	~~(1) MCEs may delegate...or in the MCE contract~~
353	Deletion	~~.~~
354	Moved to	(1) MCEs may delegate...or in the MCE contract
355	Insertion	:
356-357	Change	performance of all subcontracted work~~.~~;
358-359	Change	(~~A~~a) With respect to any MCE activities
360-361	Change	s contract with the ~~state~~Authority that the MCE is delegating to a
362-363	Change	(~~i~~A) The subcontract must specify the

364-365	Change	(~~ii~~B) The subcontractor agrees to perform
366-367	Change	(~~iii~~C) The subcontract must either provide
368-369	Change	remedies in instances where the ~~state~~Authority or the MCE determines that the
370-371	Change	(~~B~~b) The subcontractor agrees to comply
372	Insertion	requirements in the MCE contract:
373	Insertion	(A) The subcontractors...to IHCP Providers.
374	Insertion	(B) Timely payments means...calendar days of billing.
375-376	Change	necessary to support the MCE and the ~~state~~Authority
377	Deletion	410-141-3510 Provider Contracting
378-379	Change	(1) ~~CCOs~~MCEs shall
380-381	Change	shall ~~select providers using universal application~~develop policies and
382	Insertion	and procedures for credentialing
383-384	Change	credentialing ~~procedures and objective~~providers to include quality
385-386	Change	quality ~~information. CCOs shall take steps~~standards and a process to remove providers from their
387	Insertion	provider network if they fail to meet the objective quality standards
388-389	Change	objective quality standards~~.~~:
390-391	Change	(a) ~~CCOs~~MCEs shall ensure that all participating
392	Insertion	that all participating providers as defined in OAR 410-141-3500 providing coordinated care services
393-394	Change	upon initial contract with the ~~CCO~~MCE and re-credentialed no less frequently
395-396	Change	National Practitioners Databank. ~~CCOs~~MCEs shall accept both the Oregon Practitioner
397-398	Change	Practitioner Recredentialing Application~~.~~:
399-400	Change	(b) ~~CCOs~~MCEs shall screen their
401	Insertion	shall screen their participating providers to be in compliance with

402-403	Change	documentation for audit purposes.;
404-405	Change	(c) ~~CCOs~~MCEs may elect to contract for or to
406-407	Change	directly, contracted, or delegated, ~~CCOs~~MCEs shall:
408-409	Change	(B) Provide training for ~~CCO~~MCE staff and participating providers
410-411	Change	applicable administrative rules, and the ~~CCOs~~MCEs administrative policies.
412-413	Change	(d) The ~~CCO~~MCE shall provide accurate and timely
414-415	Change	(C) If ~~a CCO~~an MCE knows or has reason to know that
416	Insertion	(D) If an MCE removes a...quality standards.
417-418	Change	(e) ~~CCOs~~MCEs may not refer members to or use
419-420	Change	(A) Have been terminated from ~~OHP~~Medicaid;
421-422	Change	(f) ~~CCOs~~MCEs may not accept billings for services
423-424	Change	exclusion, conviction, or termination. ~~CCOs~~MCEs shall recoup any monies paid for
425-426	Change	(g) ~~CCOs~~MCEs shall require each atypical provider
427-428	Change	with services by the provider. ~~CCOs~~MCEs shall require each qualified provider
429-430	Change	(2) ~~A CCO~~An MCE may not discriminate with respect
431-432	Change	respect to participation in the ~~CCO~~MCE against any health care provider
433-434	Change	that license or certification. If ~~a CCO~~an MCE declines to include individual
435-436	Change	(a) Require that ~~a CCO~~an MCE contract with any health care provider
437-438	Change	participation established by the ~~CCO~~MCE; or
439-440	Change	(b) Preclude the ~~CCO~~MCE from establishing varying reimbursement
441-442	Change	(3) ~~A CCO~~An MCE shall establish an internal review
443-444	Change	to the Authority under sections (~~4~~3) and (

445-446	Change	) and (~~5~~4) of this rule, the Authority shall
447-448	Change	the aggrieved provider and the ~~CCO~~MCE to participate in the administrative
449-450	Change	the Authority shall consider the ~~CCO~~MCE
451-452	Change	party in an appeal under sections (~~4~~3) through (
453-454	Change	) through (~~6~~4) of this rule shall be awarded
455	Insertion	(6) MCEs shall not apply...25 USC 1621t and 1647a.
456	Insertion	(7) MCEs shall not...in another State.
457	Insertion	(8) MCEs shall offer...within the MCE network.
458	Deletion	410-141-3515
459-460	Change	410-141-3515 ~~Accessibility~~Network Adequacy
461	Deletion	~~(1)~~
462	Insertion	(1) MCEs shall maintain and monitor
463	Insertion	providers that is sufficient in number, provider type, and geographic distribution to
464	Insertion	ensure adequate service capacity and availability to provide available and timely
465	Insertion	access to medically appropriate and culturally responsive covered services
466-467	Change	covered services ~~for~~to both current members...will become enrolled as members.
468	Deletion	~~(2)~~
469	Insertion	(2) The MCE shall develop a provider
470	Deletion	~~(3)~~
471	Insertion	(3) The MCE shall meet access-to-care
472-473	Change	quantitative network access standards ~~specified~~defined in rule and
474-475	Change	and ~~published by the Authority~~contract.
476-477	Change	(5) ~~MCEs~~CCOs shall ensure access to integrated
478-479	Change	developing its provider network, the ~~MCE~~CCO shall anticipate access needs so
480-481	Change	especially those with behavioral health ~~issues~~conditions, in the most appropriate and independent

482-483	Change	(7) ~~MCEs~~CCOs shall ensure all members can access
484	Insertion	accommodation and language needs of individuals with LEP
485	Insertion	LEP as defined in 410-141-3500 and people with disabilities in
486	Insertion	rules including but not limited to ORS 659A, Title VI of the...Rights Act of 1964, Section 1557 of the Affordable Care
487-488	Change	1557 of the Affordable Care Act ~~and~~, the Americans with Disabilities
489	Insertion	Americans with Disabilities Act, and Section 504 of the...Act of 1973.
490-491	Change	(9) ~~MCEs~~CCOs shall make the services it provides
492	Deletion	those services locally by providers ~~sufficiently~~ qualified and specialized to treat
493	Insertion	multiple chronic conditions, or have behavioral health
494-495	Change	behavioral health ~~issues~~conditions, or who are children receiving
496-497	Change	policies and procedures to ensure~~:~~:
498	Insertion	(a)
499	Deletion	~~(a)~~ Access to providers of pharmacy,
500-501	Change	ancillary, and behavioral health services~~.~~:
502	Deletion	~~(b)~~
503	Insertion	(b) Priority access for pregnant women
504	Insertion	intervention, targeted supportive services, oral and behavioral health treatment.
505-506	Change	(11) ~~MCEs~~CCOs shall have policies and procedures
507	Deletion	~~(a)~~
508	Insertion	(a) Physical health
509	Insertion	Physical health:
510	Deletion	~~(A)~~
511	Insertion	(A) Emergency care: Immediately or referred
512-513	Change	s condition~~.~~:

514	Deletion	~~(B)~~
515	Insertion	(B) Urgent care: Within 72 hours or
516-517	Change	accordance with OAR 410-141-3840~~.~~:;
518	Deletion	~~(b)~~
519	Insertion	(b) Oral care
520	Insertion	Oral care:
521	Insertion	(A)
522	Deletion	~~(A)~~ Emergency oral care: Seen or treated
523	Deletion	~~(B)~~
524	Insertion	(B) Urgent oral care: Within one week
525-526	Change	accordance with OAR 410-123-1060~~.~~:;
527-528	Change	that makes a period of longer than ~~8~~eight weeks appropriate.
529	Insertion	(c) Behavioral health:
530-531	Change	for all populations: Immediately~~.~~:;
532	Insertion	health care for priority populations :
533-534	Change	services described in OAR 309-019-0135~~.~~:;
535-536	Change	days from placement on a waitlist~~.~~:;
537-538	Change	days from placement on a waitlist~~.~~:;
539-540	Change	Assessment and entry within 72 hours~~.~~:;
541-542	Change	72 hours for assessment and entry~~.~~:;
543	Insertion	with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority
544-545	Change	a second appointment occurring ~~no more than 14 days...within 48 days~~as clinically appropriate.
546-547	Change	accommodation due to a disability, or who ~~are~~have limited English proficiency, living in a household where there
548-549	Change	English or there is no telephone~~.~~:;
550	Insertion	procedures shall ensure the provision of Oregon certified or
551	Insertion	certified or Oregon qualified interpreter services by
552	Insertion	the MCE or its representatives :
553-554	Change	of non-English-speaking members~~.~~:;

555-556	Change	communicate instructions to the member~~.~~ ;
557	Insertion	that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for
558	Insertion	s care. Whenever possible MCES...defined in 45 CFR 92.4;
559-560	Change	non-participating providers when necessary~~.~~ ;
561-562	Change	(f) MCEs shall ~~have a plan for ensuring~~collect and actively...accessibility to ensure compliance with these
563	Insertion	compliance with these language access requirements
564-565	Change	requirements ~~and shall monitor for compliance.~~ ;
566	Insertion	(g) MCEs shall report to...of any required forms:
567	Insertion	(A) Using the interpreter...Monday of each January;
568	Insertion	(B) MCEs shall complete a...July, and October;
569	Insertion	(C) MCEs shall complete...in the MCE contract.
570	Insertion	on provider-to-enrollee ratios, interpretation...MCE's provider network, travel time and distance to providers,
571	Insertion	(14) MCEs must report annually to the Authority such access data
572-573	Change	not limited to capacity reports~~, an annual analysis of behavioral~~ on:
574	Insertion	(a) Behavioral health access
575-576	Change	health access~~, and an annual analysis of~~ ;
577	Insertion	(b) Interpreter utilization by the MCE
578-579	Change	s ~~contracted behavioral~~provider network;
580	Insertion	(c) Behavioral health
581-582	Change	health ~~workforce~~provider network.
583-584	Change	failing to keep the appointment~~.~~ ;
585	Deletion	~~(i) Determining why appointments are not kept;~~
586	Deletion	~~(ii)~~

587	Insertion	(A) Timely rescheduling of missed appointments,
588	Deletion	~~(iii)~~
589	Insertion	(B) Documentation in the clinical record
590	Deletion	~~(iv)~~
591	Insertion	(C) Recall or notification efforts;
592	Deletion	~~(v) Outreach services.~~
593	Insertion	(D) Method of member follow up.
594	Deletion	~~(c)~~
595	Insertion	(c) If failure to keep a scheduled appointment
596	Insertion	services as medically appropriate;
597	Insertion	(d) Recognition of...s missed appointment.
598-599	Change	(17) ~~MCEs~~CCOs must contract with the following
600-601	Change	chemical dependency treatment services ~~and notify the Authority...executing new contracts.~~;
602-603	Change	(b) Any ~~dental~~oral care organizations necessary to
604-605	Change	(18) ~~MCEs~~CCOs shall assess the needs of their
606-607	Change	members are referred and eligible~~.~~ ;
608	Deletion	~~(a) MCEs~~
609	Insertion	(a) CCOs shall report the number of individuals
610-611	Change	community treatment services available~~.~~;
612	Deletion	~~(b)~~
613	Insertion	(b) If
614-615	Change	If ~~ten~~10 or more members in a CCO region
616	Deletion	~~(i)~~
617	Insertion	(A) Increasing team capacity to a size
618	Deletion	~~(ii)~~
619	Insertion	(B) Adding additional Assertive Community
620-621	Change	(~~iii~~C) When no appropriate Assertive
622-623	Change	Treatment provider is available, the ~~MCE~~CCO shall consult with the Authority
624-625	Change	Statutory/Other Authority: ORS

		~~413.032~~413.042, 414.615, 414.625, 414.635 & 414.651
626	Deletion	
627	Insertion	preventive and wellness services.
628-629	Change	Identify current and monitor ongoing ~~HI~~HIE adoption rates, divided by provider
630-631	Change	shall be retained for a minimum of ~~ten~~10 years after the date of services
632-633	Change	section shall retain records for ~~ten~~10 years from the final date of the
634-635	Change	accessible all records for a minimum of ~~ten~~10 years. County agencies participating
636-637	Change	all appeals and grievances for ~~ten~~10 years following requirements specified
638	Deletion	410-141-3525 Outcome and Quality
639	Insertion	accreditation organization results, and Healthcare Effectiveness...and Information Set (HEDIS
640	Insertion	HEDIS) measures as required by DCBS in
641	Deletion	most recent accreditation review ~~in accordance with CFR 42 §438.332~~.
642	Deletion	Measures are selected by OHA; with ~~specifically~~ the incentive measures
643-644	Change	the incentive measures ~~are~~specifically adopted by the Metrics and Scoring
645-646	Change	Metrics and Scoring Committee website located at https://w...ics.aspx.
647-648	Change	(5) MCEs shall ~~implement~~maintain an
649-650	Change	an ~~ongoing comprehensive...program, QAPI~~effective process for monitoring, evaluating, and
651-652	Change	plan, and the standards in the ~~MCEMCE~~MCE
653	Deletion	procedures that are in accordance with ~~requirements set for in CFR 42 §438.330,~~ relevant law and the community standards
654	Deletion	the community standards for care, ~~and/~~or
655	Insertion	or = in accordance with accepted medical practice,

656-657	Change	workforce data provided by the Authority.;
658-659	Change	(f) Undertake performance improvementQI projects that are designed to improve
660	Deletion	quality and utilization of services. Projects must be...enrollee satisfaction.
661-662	Change	policies and procedures that assure it collectsthe collection of timely data including health disparities
663	Insertion	data required by rule or contract (or both) that allows the MCE to conduct
664	Insertion	guidelines consistent with 42 CFR § 438.236 and the MCE contract that
665	Insertion	medical-centric measures such as The National Committee of...Assurance's (NCQAs) eCQMs or HEDIS that have state or
666	Deletion	or national normative statistics.;
667-668	Change	the work of the QI Committee. The Quality ImprovementQI Coordinator is generally responsible
669-670	Change	(b) MCEs shall conductConduct and submit to the Authority an
671-672	Change	annual written evaluation of the QAPIQI Program and of member care as measured
673-674	Change	member care. The evaluation of the QAPIQI program and member care is to include
675-676	Change	program and member care is to include an assessment of annual...implemented; a plan ofa description of completed and ongoing
677-678	Change	ongoing improvementQI activities
679-680	Change	activities to address gaps, which...for MCE's members; and, member education and an evaluation of the overall effectiveness of the QI
681-682	Change	effectiveness of the QI program. MCEs shall submit theThis evaluation
683-684	Change	evaluation to the Authority and,...evaluation criteria. shall include:
685	Insertion	(A) Prevention programs;
686	Insertion	(B) Care of members who are in the ICC

		program;
687	Insertion	(C) Disease management programs;
688	Insertion	(D) Adverse outcomes of...in the ICC program;
689	Insertion	(E) Actions taken by the...to care and services.
690	Insertion	significant member complaints and appeals as required in OAR 410–141-3915;
691	Insertion	(12) MCEs that are NCQA...60 days of issuance.
692	Deletion	
693-694	Change	Medicaid Services (CMS) or to the ~~state~~Authority;
695-696	Change	(c) Granting ~~member's,~~members the right to terminate enrollment
697	Deletion	410-141-3540 Member Protections
698-699	Change	(1) In the event of a finding of ~~CCO~~MCE impairment by the Authority, or
700	Deletion	Authority, or of a termination of ~~certification as a CCO or of~~ the
701-702	Change	the ~~CCO~~MCE contract, members of the
703-704	Change	contract, members of the ~~CCO~~MCE shall be offered disenrollment
705-706	Change	offered disenrollment from the ~~CCO~~MCE and enrollment in accordance with
707-708	Change	only in the event of a finding of ~~CCO~~MCE impairment by the Authority or
709	Deletion	Authority or of a termination of ~~certification or of~~ the
710-711	Change	the ~~CCO~~MCE contract, any covered health care
712-713	Change	member of the impaired or terminated ~~CCO~~MCE shall be considered to have been
714-715	Change	contract between the provider and the ~~CCO~~MCE with whom the member was enrolled
716-717	Change	(3) Each contract between ~~a CCO~~an MCE and a provider of health services
718-719	Change	services shall provide that if the ~~CCO~~MCE fails to pay for covered health

720-721	Change	provider for any amounts owed by the ~~CCO~~MCE.
722-723	Change	the contracting provider and the ~~CCO~~MCE has not been reduced to writing
724-725	Change	provider for any amounts owed by the ~~CCO~~MCE.
726-727	Change	collect any amounts owed by the ~~CCO~~MCE for which the member is not liable
728	Deletion	~~(a) Deductible or coinsurance amounts;~~
729	Deletion	~~(b~~
730	Insertion	(a) Health services not covered by
731-732	Change	Health services not covered by the ~~CCO~~MCE, if a valid
733	Insertion	, if a valid OHP Client Agreement to...for Health Services form OHP 3165, or facsimile, signed
734-735	Change	(~~c~~b) Health services rendered after
736-737	Change	termination of the contract between the ~~CCO~~MCE and the provider, unless the health
738	Deletion	410-141-3545 Coordinated Care Organization
739-740	Change	410-141-3545 Coordinated Care Organization ~~Substance Use Disorder~~Behavioral Health Provider, Treatment and Facility
741	Deletion	(1) ~~Certain Behavioral Health...Care Organization (CCO).~~
742-743	Change	~~(2) Substance Use Disorder (SUD)~~Behavioral health treatment services are covered
744-745	Change	under the following circumstances~~.~~:
746-747	Change	(a) ~~The provision of SUD services shall comply~~Provider Organizations...health services shall:
748	Insertion	(A) Be certified
749	Moved to	by the Authority as described in OAR
750	Insertion	309-008-0250 for the...services provided; and
751	Insertion	(B) Comply with applicable rules, including
752	Insertion	with applicable rules, including but not limited to, those defined in OAR chapter
753-754	Change	those defined in OAR chapter ~~415, divisions~~

		~~12, 20,...18, 19, and 22;~~309 and any requirements in the CCO
755	Deletion	~~(b) Outpatient substance...a certificate issued~~
756	Moved from	~~by the Authority as described in OAR~~
757	Deletion	~~415-012-0000 for the scope of services provided.~~
758	Insertion	(b) A certificate may not...in OAR 309-008-0250(4);
759	Insertion	(c) Provider...services shall:
760-761	Change	(~~c~~A)
762-763	Change	) ~~Any facility that meets~~Meet the definition of a residential
764	Deletion	residential treatment facility ~~for substance dependent persons~~ under ORS 430.010
765	Insertion	under ORS 430.010, 430.306 and 443.400
766-767	Change	and 443.400~~, or of a detoxification...in ORS 430.306, shall be~~;
768	Insertion	(B) Be licensed by the Authority as described
769	Insertion	by the Authority as described in ORS 443.725 and OAR
770	Insertion	OAR chapter 415
771-772	Change	415~~-012-0000~~ divisions 12 and 50 for the scope of service provided
773-774	Change	for the scope of service provided~~.~~; and
775	Deletion	~~(d) Detoxification...for the scope provided.~~
776	Insertion	(C) Comply with...in the CCO contract.
777	Deletion	Statutory/Other Authority: ORS ~~192.527, 192.528,~~ 413.042
778-779	Change	413.042~~ &~~, 414.065
780	Insertion	414.065, 430.010, 430.306, 443.400 & 443.725
781	Deletion	Statutes/Other Implemented: ORS ~~192.527, 192.528,~~ 413.042,
782	Deletion	413.042, ~~414010,~~ 414.065
783	Insertion	414.065, 414.010, 430.306 &
784-785	Change	& ~~414.727~~443.400

786	Deletion	410-141-3550 Resolving Disputes
787-788	Change	410-141-3550 Resolving Disputes between ~~CCOs~~MCEs and the Authority
789-790	Change	(1) If ~~a CCO~~an MCE has a dispute with the Authority
791-792	Change	perceived as adversely affecting ~~a CCO~~an MCE, the
793-794	Change	, the ~~CCO~~MCE may submit a request to the Director
795-796	Change	decision that is perceived by the ~~CCO~~MCE to adversely affect the
797-798	Change	to adversely affect the ~~CCO~~MCE and is not otherwise reviewed as
799-800	Change	a provider discrimination appeal~~.~~ ;
801-802	Change	has breached its contract with ~~a CCO.~~ an MCE;
803-804	Change	(c) This ~~CCO~~MCE process is not mandatory, and it
805-806	Change	it need not be exhausted before ~~a CCO~~an MCE seeks judicial review or brings
807-808	Change	other form of action related to any ~~CCO~~MCE/Authority dispute related decision.
809-810	Change	(2) Within ~~thirty~~30 calendar days of the conclusion
811-812	Change	time as may be agreed to by the ~~CCO~~MCE and the Authority, the Authority
813-814	Change	administrative review to the initiating ~~CCO~~MCE and any other affected
815-816	Change	and any other affected ~~CCO~~MCE. Should a resolution be reached
817-818	Change	(3) If the dispute between the ~~CCO~~MCE and the Authority remains unresolved
819-820	Change	(4) Not more than ~~ten~~10 business days after receipt of
821-822	Change	administrative review decision, the ~~CCO~~MCE may contact the Director of the
823-824	Change	of the Authority indicating the ~~CCO~~MCE
825-826	Change	mediation. In that request, the ~~CCO~~MCE may

		request to stay the administrative
827-828	Change	the Authority will grant if the ~~CCO~~MCE alleges sufficient facts and provides
829-830	Change	Authority shall respond within ~~ten~~10 business days of the date of the
831	Insertion	of the date of the stay request.
832-833	Change	(5) After both the ~~CCO~~MCE and the Authority agree to enter
834-835	Change	s services. If the ~~CCO~~MCE and the Authority are unable to
836-837	Change	dispute is likely to impact another ~~CCO~~MCE, the Authority shall notify all
838-839	Change	the Authority shall notify all ~~CCOs~~MCEs potentially impacted by the dispute
840-841	Change	an opportunity for the impacted ~~CCOs~~MCEs to participate in the dispute resolution
842-843	Change	the dispute resolution process. ~~CCOs~~MCEs that opt into the process have,
844-845	Change	rights and responsibilities as the ~~CCO~~MCE that initiated the dispute.
846-847	Change	(7) The ~~CCO~~MCE and the Authority shall share in
848-849	Change	(8) Within ~~ten~~10 business days of a selection of
850-851	Change	the parties and the mediator, the ~~CCO~~MCE and the Authority shall submit
852-853	Change	information of all participating ~~CCOs~~MCEs to the extent the information is
854	Deletion	410-141-3555 Resolving Disputes
855-856	Change	Entities and CCOs that Concern CCO ~~Contact~~Contract Award
857-858	Change	agreement on contract terms within ~~ten~~10 calendar days of the face-to-face
859-860	Change	(8) Within ~~ten~~10 calendar days of a referral to
861-862	Change	(9) Within ~~ten~~10 calendar days of receiving the
863-864	Change	Quality or performance requirements~~;~~.
865-866	Change	determination to the Authority for ~~ten~~10 calendar days to allow the parties

867-868	Change	not reached an agreement after ~~ten~~10 calendar days, the arbitrator shall
869	Deletion	410-141-3560 Resolving Contract
870-871	Change	(CCOs) and Health Care Entities (~~HCE~~HCEs) shall participate in good faith
872-873	Change	(d) Within ~~ten~~10 business days of a selection of
874-875	Change	(d) Within ~~ten~~10 business days of a selection of
876	Deletion	410-141-3565 Managed Care Entity
877	Deletion	410-141-3565 Managed Care Entity Billing ~~(Revised 8/2/19)~~
878-879	Change	an alternative liability or TPL~~:~~;
880	Insertion	the Authority specifies otherwise. No contracting provider...and under 410-120-1280:
881	Insertion	(a) A client may not be...client or the Division;
882	Insertion	(b) A client may not be...not obtained, etc.).
883-884	Change	MCE and the participating provider~~.~~;
885-886	Change	sharing on a fee-for-service basis~~.~~;
887-888	Change	Medicare or a Medicare Advantage plan~~.~~;
889	Insertion	(a)
890	Deletion	~~(a)~~ Providers must be enrolled in Oregon
891-892	Change	the MCE with their Medicare claims~~.~~;
893	Deletion	~~(b)~~
894	Insertion	(b) MCE and affiliated Medicare Advantage
895-896	Change	duplicate provider submission of claims~~.~~;
897	Deletion	~~(c)~~
898	Insertion	(c) Federal law bars Medicare providers
899-900	Change	deductibles, coinsurance, and copays~~.~~;
901	Deletion	~~(d)~~
902	Insertion	(d) MCE must inform providers of rules
903-904	Change	referral procedures had been followed~~:~~;
905	Insertion	(a) Sections (12) and (14) only apply to services provided
906	Deletion	410-141-3570 Managed Care Entity

907-908	Change	(1) MCEs ~~must~~shall meet the data content and submission
909-910	Change	(2) MCEs ~~must~~shall collect service information in
911-912	Change	must utilize the HIPAA standards~~.~~;
913	Deletion	submit encounter claims for all ~~services, whether they are~~ covered services
914-915	Change	covered services ~~or other~~, except for health-related services, provided
916-917	Change	OAR 410-120-0000 and 410-141-3500~~.~~;
918	Moved to	determined that liability exists; even if the MCE did not...any payment for a claim
919	Insertion	,
920	Deletion	determined that no liability exists~~,~~
921	Moved from	~~even if the MCE did not...any payment for a claim~~;
922-923	Change	(3) MCEs ~~must~~shall follow the DCBS standards for electronic
924-925	Change	(4) MCEs ~~must~~shall submit all
926	Insertion	submit all valid unduplicated encounter claims: professional,
927-928	Change	days of the date of adjudication~~.~~;
929-930	Change	(a) MCEs ~~must~~shall ensure all pharmacy encounter claims
931-932	Change	(A) MCEs ~~must~~shall only use the two types of provider
933-934	Change	(B) MCEs ~~must~~shall make an adjustment to any encounter
935-936	Change	void the encounter claim within ~~14~~30 days of notification by the Authority
937-938	Change	(G) MCEs ~~must~~shall make all collected and reported
939-940	Change	remains in a “must correct” status~~.~~;
941-942	Change	(6) MCEs ~~must~~shall comply with the following hysterectomy
943	Insertion	(C) Informing the MCE, the informed consent is missing
944	Insertion	and the payment must be recouped, and the

		associated encounter claim
945-946	Change	request by the Authority, MCEs ~~must~~shall furnish information regarding rebates
947	Deletion	410-141-3575 MCE Member Relations:
948-949	Change	interpretation, and sighted guide~~.~~;
950-951	Change	purpose of marketing by the MCE~~.~~;
952-953	Change	to enroll in that particular MCE~~.~~;
954-955	Change	intended to market to potential members~~.~~;
956-957	Change	education and health related events~~.~~;
958-959	Change	member to enroll in a particular MCE~~.~~;
960-961	Change	yet enrolled with a specific MCE~~.~~;
962	Insertion	non-English languages that are identified during the eligibility process as the preferred written language
963-964	Change	(~~a~~A) Five percent of the MCE
965-966	Change	(~~b~~B) One thousand of the MCE
967-968	Change	s members~~.~~;
969-970	Change	(3) The following ~~communications with~~outreach to members or potential members are
971-972	Change	fairs, or health-related events~~.~~;
973-974	Change	(b) ~~A~~An MCE or its subcontractor
975-976	Change	s enrollment~~.~~;
977	Deletion	~~(c) A process for appeals...s edits or denials;~~
978	Deletion	~~(d~~
979	Insertion	(c) A marketing materials submission
980-981	Change	(~~e~~d) An update of plan availability
982	Deletion	410-141-3580 MCE Member Relations:
983	Insertion	adopted by the Authority there under .
984	Insertion	elements and be made readily accessible as defined in 42 CFR 438.10.
985	Insertion	members regarding the rights of American Indians
986	Insertion	Indians and Alaskan Natives:
987	Insertion	informational materials shall state that American Indians

988	Insertion	Indians and Alaskan Natives enrolled in the MCEs may select
989-990	Change	provide primary care services to such ~~Indian~~American Indians and Alaskan Natives.
991	Insertion	explain to potential members that American Indians
992	Insertion	Indians and Alaskan Natives enrolled in an MCE shall also be
993	Insertion	an IHCP or out of network, and American Indians
994	Insertion	Indians and Alaskan Natives may be referred by out-of-network
995-996	Change	primary language is not English~~.~~;
997-998	Change	(b) MCEs shall ~~honor~~accommodate requests made by potential members,
999-1000	Change	or alternative format materials~~.~~;
1001-1002	Change	Education plan described in 410-141-~~AAAA SDOH/HE (4) (b)~~3735.
1003	Deletion	410-141-3585 MCE Member Relations:
1004-1005	Change	languages in its particular service area ~~MCE.~~ MCEs shall accommodate requests made
1006-1007	Change	members as stated in 42 CFR 438.10~~.~~;
1008-1009	Change	grievance, appeals, or hearings~~.~~;
1010-1011	Change	Education plan described in 410-141-~~AAAA SDOH/HE (4) (b)~~3735 whether providers have verifiable
1012	Insertion	access services also applies to member representatives, family members and caregivers with
1013-1014	Change	and materials in alternate formats~~.~~;
1015-1016	Change	(~~I~~L) Information on contracted hospitals
1017-1018	Change	(d) ~~Explanation~~An explanation of ICC services and how eligible
1019	Insertion	services and how eligible members may access those services. MCEs should ensure
1020	Deletion	410-141-3590 MCE Member Relations:
1021	Insertion	(e) Have a friend, family member, member representative, or advocate present during

		appointments
1022-1023	Change	(~~i~~L) Receive oversight, care coordination
1024-1025	Change	(~~i~~L) Help in the creation of a treatment
1026	Deletion	410-141-3600 MCE Assessment: Definitions
1027	Deletion	410-141-3601 MCE Assessment: General
1028-1029	Change	received during a calendar quarter~~.~~;
1030-1031	Change	2019, is 1.5 percent~~.~~;
1032	Deletion	410-141-3605 MCE Assessment: Disclosure
1033	Deletion	410-141-3610 MCE Assessment: Calculation,
1034	Deletion	410-141-3615 MCE Assessment: Filing
1035	Deletion	410-141-3620 MCE Assessment: Determining
1036	Deletion	410-141-3625 MCE Assessment: Authority
1037	Deletion	410-141-3630 MCE Assessment: Determining
1038	Deletion	~~(1)~~
1039	Insertion	(1) In the case of a failure by the
1040	Deletion	~~(2)~~
1041	Insertion	(2) Best of its information and belief
1042	Deletion	~~(3)~~
1043	Insertion	(3) The Authority's determination of
1044	Deletion	410-141-3635 MCE Assessment: Financial
1045-1046	Change	the reasonable control of the MCE~~.~~;
1047	Deletion	410-141-3640 MCE Assessment: Notice
1048-1049	Change	the Authority has determined that ~~a~~an MCE has an MCE assessment deficiency
1050-1051	Change	(~~i~~L) A statement of the MCE's right
1052	Deletion	410-141-3650 MCE Assessment: Final
1053	Deletion	~~(1)~~ The Authority shall issue a final
1054-1055	Change	(~~a~~1) The MCE did not make a timely
1056-1057	Change	make a timely request for a hearing~~.~~;
1058-1059	Change	(~~b~~2) Any part of the deficiency or
1060-1061	Change	penalty was upheld after a hearing~~.~~;
1062-1063	Change	(~~c~~3) Upon agreement of the MCE and
1064	Deletion	410-141-3655 Assessment: Remedies
1065	Deletion	~~(1)~~ Any amounts due and owing under
1066-1067	Change	(~~a~~1) Collection activities including

1068-1069	Change	owed to the MCE by the Authority.;
1070-1071	Change	(b2) Every payment obligation shall
1072	Deletion	410-141-3700 CCO Application and
1073-1074	Change	contract for coordinated care services.;
1075-1076	Change	response to a Request for Applications.;
1077-1078	Change	binds the applicant to the contract.;
1079-1080	Change	contents and release of information.;
1081	Deletion	410-141-3705 Criteria for CCOs
1082-1083	Change	elements described in this rule.;
1084-1085	Change	be required to address in the RFA. .;
1086-1087	Change	s adopted reports and policies.;
1088-1089	Change	(c) theThe Authority
1090-1091	Change	of the CCO system. .;
1092-1093	Change	Coordinated Health Care Delivery System. .;
1094-1095	Change	applicant “potentially eligible.;”
1096-1097	Change	in an amount equal to at least 5five percent of the average combined
1098-1099	Change	health disparities in the community.;
1100-1101	Change	assessment before operating as a CCO.;
1102	Deletion	(7) Dental care...DCO in its service area.
1103	Deletion	(8
1104	Insertion	(7) CCOs shall have agreements in
1105-1106	Change	developed unless good cause can be shown.;
1107-1108	Change	developed unless good cause can be shown.;
1109-1110	Change	(98) CCOs shall provide integrated,
1111-1112	Change	(109) CCOs shall develop mechanisms
1113-1114	Change	(1110) CCOs shall operate in a manner
1115-1116	Change	(1211) CCOs shall assure that members
1117-1118	Change	Disorder (SUD) service providers, and dentaloral health care when the CCO includes a dental
1119-1120	Change	(1312) CCOs shall assure that each member
1121-1122	Change	(1413) CCOs shall address the supportive
1123-1124	Change	other issues including mental health.;
1125-1126	Change	(1514) CCOs shall assure that members

1127-1128	Change	(~~16~~15)
1129-1130	Change	Health Workers (THW). THWs include~~:~~;
1131	Insertion	(e) Youth support specialist;
1132-1133	Change	(~~17~~16) The applicant shall describe its
1134	Insertion	THWs identified in OAR 410-180-0305;
1135-1136	Change	(~~18~~17) Services and supports shall be
1137-1138	Change	(~~19~~18) CCOs shall prioritize working
1139-1140	Change	(~~20~~19) CCOs shall participate in the
1141-1142	Change	(~~21~~20) CCOs shall implement to the maximum
1143-1144	Change	communities, and underserved populations~~.~~;
1145-1146	Change	(~~22~~21) CCOs
1147-1148	Change	(~~23~~22) CCOs are required to use alternative
1149-1150	Change	(~~24~~23) CCOs shall use health information
1151-1152	Change	(~~25~~24) CCOs shall report on outcome and
1153-1154	Change	(~~26~~25) CCOs shall be transparent in reporting
1155-1156	Change	(~~27~~26) CCOs shall use best practices
1157-1158	Change	(~~28~~27) CCOs shall demonstrate sound fiscal
1159-1160	Change	needed to meet their obligations~~.~~;
1161-1162	Change	(~~29~~28) CCOs may provide coordinated care
1163-1164	Change	(~~30~~29) CCOs shall operate, administer,
1165	Deletion	410-141-3710 Contract Termination
1166	Deletion	~~(1)~~
1167	Insertion	(1) CCOs shall establish, maintain,
1168	Deletion	~~(2)~~
1169	Insertion	(2) Consumer Representative means a
1170	Deletion	~~(3)~~
1171	Insertion	(3) Each CCO
1172-1173	Change	chemical dependency treatment provider~~;~~;
1174-1175	Change	At least two members of the CAC~~.~~;
1176-1177	Change	current CAC Consumer Representative~~.~~;
1178	Deletion	~~(B) These CAC...family members.~~
1179	Insertion	(B) Any CAC member...conflicts of interest;
1180	Deletion	410-141-3720 Service Area Change
1181	Deletion	found on the CCO Contract Forms page ~~at~~. The Authority shall work with

1182-1183	Change	(a) Within ~~thirty~~30 days of the Authority
1184-1185	Change	(b) Not later than ~~fifteen~~15 calendar days from the date of
1186-1187	Change	acknowledgement to the CCO within ~~ten~~10 calendar days of receipt of the
1188-1189	Change	(5) Within ~~thirty~~30 calendar days of the date specified
1190	Deletion	support for those areas of need; and~~,~~
1191	Insertion	new members, specifically high -risk members or members with special
1192-1193	Change	(9) Within ~~sixty~~60 calendar days from the date the
1194-1195	Change	service area. The CCO shall have ~~sixty~~60 calendar days to return an executed
1196	Deletion	410-141-3725 CCO Contract Renewal
1197	Deletion	410-141-3730 Community Health Assessment
1198	Deletion	~~(Revised 7/30/19)~~
1199	Deletion	~~(2~~
1200	Insertion	(2
1201	Moved to	) The CCOs' CACs shall...of the shared CHA.
1202	Insertion	(3) In developing and maintaining
1203	Deletion	~~(a)~~
1204	Insertion	(a) County and city government representatives;
1205	Deletion	~~(b)~~
1206	Insertion	(b) Federally recognized tribes (if
1207	Deletion	~~(c)~~
1208	Insertion	(c) SDOH-
1209-1210	Change	SDOH-~~HE~~E partners, as defined in OAR 410-141-3735;
1211	Deletion	~~(d) Local public health authorities;~~
1212	Deletion	~~(e)~~
1213	Insertion	(d) Local mental health authorities
1214	Deletion	~~(f) Hospitals;~~
1215	Deletion	~~(g)~~
1216	Insertion	(e) Physical, behavioral, and oral health

1217	Insertion	(f) Federally Qualified Health Centers;
1218	Deletion	~~(h)~~
1219	Insertion	(g) Indian Health Care Providers;
1220	Deletion	~~(i)~~
1221	Insertion	(h) Traditional Health Workers;
1222	Deletion	~~(j)~~
1223	Insertion	(i) School nurses, school mental health
1224	Deletion	~~(k)~~
1225	Insertion	(j) Culturally specific organizations,
1226	Insertion	Regional Health Equity Coalitions; and
1227	Deletion	~~(l)~~
1228	Insertion	(k) Representatives from populations
1229-1230	Change	health and health care disparities~~;~~..
1231-1232	Change	(~~3~~4) The CHA must include or identify
1233-1234	Change	CHA must include or identify and ~~analyze,~~analyse at a minimum, all of the following:
1235	Deletion	~~(A)~~
1236	Insertion	(A) Access to primary prevention resources;
1237	Deletion	~~(B)~~
1238	Insertion	(B) Disproportionate, unmet, health-related
1239	Deletion	~~(C)~~
1240	Insertion	(C) Description of assets within the
1241	Deletion	~~(D)~~
1242	Insertion	(D) Systems of seamless continuum of
1243	Deletion	~~(E)~~
1244	Insertion	(F) Systems or programs of collaborative
1245-1246	Change	(g) ~~Identify programs that~~Means to promote the health and
1247	Insertion	promote the health and early intervention in the treatment of children and adolescents
1248-1249	Change	s Service Area, ~~including any treatment...of any such programs~~and whether they are sufficient and effective;
1250-1251	Change	(h) ~~Identify areas~~Areas for improvement; and
1252-1253	Change	(i) ~~Document the~~The persons, organizations,

		and entities
1254	Deletion	~~(4~~
1255	Moved from	~~) The CCOs' CACs shall...of the shared CHA.~~
1256	Deletion	CCOs and their CACs must develop~~-~~ ~~meaningful~~ baseline data on health disparities
1257-1258	Change	behavioral health status, geography, ~~living-~~ ~~setting~~neighborhood and environment, or other factors. This data will
1259	Insertion	used to identify and prioritize strategies to reduce health disparities in the development
1260	Deletion	the development of a shared CHP ~~or shared CHP priorities and strategies~~. The CCOs
1261	Deletion	~~(a)~~
1262	Insertion	(a) County and city government representatives;
1263	Insertion	(b)
1264	Deletion	~~(b)~~ Federally recognized tribes (if
1265	Deletion	~~(c)~~
1266	Insertion	(c) SDOH-
1267-1268	Change	SDOH-~~HE~~E partners, as defined in OAR 410-141-3735;
1269	Deletion	~~(d) Local public health authority;~~
1270	Deletion	~~(e) Hospitals~~
1271	Deletion	~~(f)~~
1272	Insertion	(d) Local mental health authorities
1273	Deletion	~~(g)~~
1274	Insertion	(e) Physical, behavioral, and oral health
1275	Insertion	(f) Federally Qualified Health Centers;
1276	Deletion	~~(h)~~
1277	Insertion	(g) Indian Health Care Providers;
1278	Deletion	~~(i)~~
1279	Insertion	(h) Traditional Health Workers;
1280	Deletion	~~(m)~~
1281	Insertion	(i) School nurses, school mental health
1282	Deletion	~~(j)~~
1283	Insertion	(j) Culturally specific organizations,

1284	Insertion	Regional Health Equity Coalitions; and
1285	Deletion	~~(k)~~
1286	Insertion	(k) Representatives from populations
1287	Deletion	~~(a)~~
1288	Insertion	(a) CHP health priority goals are intended
1289	Deletion	~~(A)~~
1290	Insertion	(A) Closing the gap on disproportionate,
1291	Deletion	~~(B)~~
1292	Insertion	(B) Creating access to primary prevention;
1293	Deletion	~~(C)~~
1294	Insertion	(C) Building a system of seamless continuum
1295	Deletion	~~(D)~~
1296	Insertion	(D) Building on current Community resources
1297-1298	Change	to improve health or address SDOH~~/HE~~-E, or both; and
1299	Deletion	~~(E)~~
1300	Insertion	(E) Engaging the Community in the implementation
1301	Deletion	~~(b)~~
1302	Insertion	(b) The CHP strategies should be based
1303	Deletion	~~(A)~~
1304	Insertion	(A) Developing a
1305	Insertion	Developing a or supporting Health Policy that supports the
1306	Deletion	~~(B)~~
1307	Insertion	(B) Implementing
1308	Insertion	Implementing or supporting community health or SDOH
1309-1310	Change	community health or SDOH~~/HE~~-E interventions, or both, to support
1311	Deletion	~~(C)~~
1312	Insertion	(C) Developing public and private resources
1313	Deletion	~~(D)~~
1314	Insertion	(D) Designing and building a system
1315	Deletion	~~(E)~~

1316	Insertion	(E) Developing and implementing best
1317-1318	Change	toward CHP goals and strategies.;
1319-1320	Change	(d) The CHP must also include a component for...This must be developedaddress, with the input of school nurses,
1321	Deletion	adolescent health services, the Early Learning Council,...addressing the needs of adolescents and children
1322	Insertion	s Service Area and must address:
1323	Deletion	(A) Include findings
1324	Insertion	(A) Findings based on research, including adverse
1325	Deletion	including adverse childhood experiences and must identify...the goals of the plan;
1326	Deletion	(B) Evaluate the
1327	Insertion	(B) The adequacy of
1328	Deletion	adequacy of existing school-based resources including school-based health
1329-1330	Change	health centerscenter (SBHC)
1331-1332	Change	(SBHC) to meet the specific...needs in the community;networks and make recommendations relating
1333	Deletion	and adolescents in the Community, including the addition...and billing systems;
1334	Deletion	;.
1335	Deletion	(C) Take into consider...the goals of the plan;
1336	Insertion	(C) The integration of...and families; and
1337	Deletion	(D)
1338	Insertion	(D) Primary care, behavioral and oral
1339	Deletion	(10
1340	Moved from	) CCOs shall collect and...by posting on the web.
1341	Moved from	(
1342	Deletion	11
1343	Insertion	(10) In addition, CACs shall annually
1344	Deletion	410-141-3735 Social Determinants

1345	Insertion	(1) This rule defines health disparities and
1346	Moved from	and ~~establishes requirements for~~ the social determinants of health
1347	Deletion	determinants of health and equity (SDOH-E)~~ spending programs~~,
1348	Moved to	, establishes requirements for
1349	Insertion	the Supporting Health...establishes the role of the Community Advisory
1350-1351	Change	Councils in supporting SDOH-E, ~~and~~establishes requirements...establishes requirements for developing health equity infrastructure
1352-1353	Change	Coordinated Care Organization (CCO). ~~The~~This rule provides structure and guidance
1354	Moved from	~~(a) "Adjusted Net Income"...year, if relevant)~~
1355	Deletion	~~pursuant to OAR [SB 1041...rules under SAP]~~
1356	Moved from	~~, modified by the...of the Authority:~~
1357	Deletion	~~(A)~~
1358	Moved from	~~Excessive administrative...management bonuses~~
1359	Deletion	~~(B)~~
1360	Moved from	~~Improper allocation of...lines of businesses~~
1361	Deletion	~~(C)~~
1362	Moved from	~~Non-operating revenues and expenses~~
1363	Deletion	~~(D)~~
1364	Moved from	~~Adjustments to base data...rate development~~
1365	Deletion	~~(E)~~
1366	Moved from	~~Other expenses not...business purposes~~
1367	Moved from	~~(F) Payments or transfers...or subsidiaries~~
1368	Deletion	~~(b~~
1369	Insertion	(a) "Health Disparities" are the structural
1370-1371	Change	exclusion. Health disparities are the ~~metric~~indicators used to
1372-1373	Change	used to ~~measure~~track progress toward achieving health
1374	Insertion	progress toward achieving health equity.
1375-1376	Change	(~~c~~b) "Social Determinants of Health

1377-1378	Change	Determinants of Health and Equity” (SDOH-E)~~.~~:.
1379	Deletion	~~(A~~
1380	Insertion	(A) SDOH-E encompasses three terms:
1381	Insertion	(i) The social determinants of health
1382	Insertion	born, grow, work, live, and age, and are shaped by the...determinants of equity.
1383	Deletion	contribute to health inequities~~. Social determinants of...the following domains~~
1384	Moved from	~~: Neighborhood and Built...and Community Health~~
1385-1386	Change	~~.~~:.
1387-1388	Change	(~~B~~ii) The social determinants of equity
1389-1390	Change	determinants of health in communities~~.~~:.
1391	Deletion	~~(d) “SDOH-E Partner”...entity that delivers~~
1392	Moved from	~~services or programs, or...systems change, or both~~
1393	Deletion	~~to address the social...and health equity; that~~
1394	Moved from	~~the CCO has selected to...of the CCO’s SDOH-E~~
1395	Deletion	~~Spending.~~
1396	Insertion	(iii) Health-related social needs refer to
1397	Moved to	an individual’s social...or food insecurity.
1398-1399	Change	(~~e~~B)
1400	Deletion	) ~~“~~SDOH-E
1401	Deletion	SDOH-E~~ Spending” means spending on services and~~ initiatives
1402	Deletion	initiatives ~~designed to address...SDOH-E programs~~ may involve interventions that occur
1403	Deletion	~~(A) Population health...or organization;~~
1404	Deletion	~~(B) Systems change,...or organization, and,~~
1405	Deletion	~~(C) Services~~
1406	Insertion	(i) Community-level...determinants of equity;
1407	Insertion	(ii) Interventions to address individual
1408	Deletion	to address individual~~’s’~~ health-related social needs

1409	Deletion	health-related social needs~~, meaning~~
1410	Moved from	~~an individual's social...or food insecurity.~~
1411	Insertion	.
1412	Deletion	~~(f) "SDOH-E Spending...may not be limited to:~~
1413	Deletion	~~(A)~~
1414	Insertion	(3) The following definitions are specific to the Supporting Health for All through
1415	Deletion	~~(B) Boosting Up...Fund (BUILD Fund)~~
1416-1417	Change	~~(3~~:
1418-1419	Moved to	(a) "Adjusted Net Income"...year, if relevant), modified by the...of the Authority:
1420	Insertion	(A)
1421	Moved to	Excessive administrative...management bonuses
1422	Insertion	;
1423	Insertion	(B)
1424	Moved to	Improper allocation of...lines of businesses
1425	Insertion	;
1426	Insertion	(C)
1427	Moved to	Non-operating revenues and expenses
1428	Insertion	;
1429	Insertion	(D)
1430	Moved to	Adjustments to base data...rate development
1431	Insertion	;
1432	Insertion	(E)
1433	Moved to	Other expenses not...business purposes
1434	Insertion	;
1435	Moved to	(F) Payments or transfers...or subsidiaries
1436	Insertion	.
1437	Insertion	(b) "SDOH-E Partner:"
1438	Insertion	(A) A single...or a collaborative;
1439	Insertion	(B) That delivers SDOH-E related
1440	Moved to	services or programs, or...systems change, or both
1441	Insertion	within a CCO's service area; and

1442	Insertion	(C) That
1443	Moved to	the CCO has selected to...of the CCO's SDOH-E
1444	Insertion	dollars.
1445	Insertion	(4) The following
1446	Deletion	) The following general requirements
1447-1448	Change	requirements applyare specific to
1449-1450	Change	to any SDOH-E spending programthe Supporting Health for...(SHARE Initiative):
1451	Moved to	(a) For each calendar...forth in the contract
1452	Insertion	:
1453-1454	Change	(ab)
1455-1456	Change	select SDOH-E spending priorities based onthat fall into at least...four domains of SDOH-E
1457	Moved to	: Neighborhood and Built...and Community Health
1458	Insertion	, and are consistent with:
1459-1460	Change	authorities, hospitals, and other CCOs.; and
1461-1462	Change	areas identified by the Authority.:
1463-1464	Change	(bi) A portion of
1465-1466	Change	) A portion of SDOH-E Spending Program expendituresSHARE Initiative dollars must go directly to SDOH-E Partner(s)
1467	Insertion	CCOs shall enter into a contract, or a Memorandum of Understanding, with each SDOH-E Partner that defines
1468	Deletion	between the Authority and the CCO. These contracts shall be...to the Authority for.
1469	Deletion	(4) The following...to the SHARE Initiative:
1470	Moved from	(a) For each calendar...forth in the contract
1471	Deletion	.
1472	Deletion	(b) The portion of...exceed the greater of:
1473	Deletion	(A) % of adjusted net...portion calculation); or
1474	Deletion	(B) A proportion of the...in that prior year.
1475	Deletion	(c) The Authority will...by such revision.
1476	Deletion	(d) The value of the %RBC...will be the greater

		~~of:~~
1477	Deletion	~~(A) 250% RBC, or~~
1478	Deletion	~~(B) the percentage...payment restrictions.~~
1479	Deletion	~~(e) The Authority's...reserves below 200% RBC.~~
1480	Deletion	~~(5) The following...to the BUILD Fund:~~
1481	Deletion	~~(a) Dependent on...guidance documents.~~
1482	Deletion	~~(6~~
1483	Insertion	(5) Community Advisory Councils (CAC)
1484-1485	Change	Community Advisory Councils (CAC)~~.~~:
1486-1487	Change	spending on SDOH-E, including the ~~SDOH-E Spending Programs~~SHARE Initiative, and health-related services community
1488-1489	Change	as defined in OAR 410-141-3845. ~~Interested~~CCOs shall have a...that applies to its CAC members
1490-1491	Change	CAC members~~—~~ and accounts for
1492-1493	Change	for ~~example, a member whose...decision-making process~~ financial interests...SDOH-E spending:
1494-1495	Change	making decisions on these issues~~, as well as~~. These reports shall also detail the CCO
1496-1497	Change	s efforts to ~~align~~ensure the CAC
1498-1499	Change	s composition ~~with~~is representative of the communities in the CCO
1500	Deletion	the CCO ~~membership~~
1501-1502	Change	s ~~demographic composition~~service area, and
1503	Insertion	and in alignment with its CHP priorities
1504	Insertion	CHP priorities. CCOs should consider...on their CAC(s). These reports will be posted publicly
1505	Deletion	~~(8~~
1506	Insertion	(6
1507	Moved to	) CCOs shall collect and...by posting on the web.
1508	Moved to	(
1509	Insertion	7) Health Equity Infrastructure

1510-1511	Change	) Health Equity Infrastructure~~.~~:;
1512	Insertion	(a) The term “Health...policies;
1513	Insertion	(b) The “Health Equity...Equity Infrastructure;"
1514-1515	Change	(~~a~~c) CCOs shall develop and implement
1516-1517	Change	CCOs shall develop and implement ~~a~~the “Health Equity Plan” to
1518-1519	Change	“Health Equity Plan” to ~~address~~embed health
1520-1521	Change	health ~~disparities that exist...the CCOs' service areas~~equity as a value and...appropriate services. The health equity plan shall include
1522-1523	Change	meaningful community engagement~~.~~:;
1524-1525	Change	objectives, activities and metrics~~.~~:;
1526	Deletion	~~(C) A plan for ensuring...network are trained on~~
1527	Insertion	(C) Organizational and...Bias training plan:
1528	Insertion	(i) CCO shall incorporate...plan and programs;
1529	Insertion	(ii) CCO shall align cultural responsiveness
1530-1531	Change	cultural responsiveness~~,~~ and implicit bias
1532-1533	Change	implicit bias~~, and anti-discrimination...Authority's standards~~ trainings with the...in OAR 943-090-0020;
1534	Insertion	(iii) CCO shall adopt the...in OAR 943-090-0010;
1535	Insertion	(iv) CCO shall provide...in all such trainings;
1536	Insertion	(v) CCO's shall require...set forth in ORS 676.850.
1537-1538	Change	(~~b~~d) The health equity plan
1539	Insertion	) The health equity plan and the language access...OAR 410-141-3515 and shall be submitted
1540	Insertion	shall be submitted every year to the Authority for review and
1541-1542	Change	Authority for review and approval~~.~~:;
1543-1544	Change	(~~c~~e) CCOs shall designate a
1545	Insertion	) CCOs shall designate a Single Point of Accountability. The single point of

		accountability
1546-1547	Change	single point of accountability ~~for health equity with~~can also be called the...Equity Administrator:
1548	Insertion	(A) The Single Point of...and CCO service area;
1549	Insertion	(B) The Single Point of...shall have budgetary decision-
1550-1551	Change	authority and health equity expertise~~.~~;
1552	Insertion	(C) The Single Point of...and job title;
1553	Insertion	(D) The CCO shall inform...the Health Equity Plan;
1554	Insertion	(E) The Single Point of...and governing board.
1555	Deletion	410-141-3740 Traditional Health
1556-1557	Change	(1) The Authority ~~seeks to ensure~~requires that all CCO members
1558	Insertion	that all CCO members based on their health needs must have access to certified traditional
1559-1560	Change	s care team ~~to improve~~in clinical and...members have improved access to appropriate services
1561-1562	Change	access to appropriate services ~~and~~. The THWs, as a part of...member's care team, must participate in processes affecting
1563-1564	Change	s care and ~~services. THW is defined in OAR 410-180-0305~~service needs. THW is defined in OAR 410-180-0305.
1565-1566	Change	with this rule and the CCO contract~~.~~;
1567	Deletion	~~(B) Measurement standards and benchmarks;~~
1568	Insertion	(B) Benchmarks and...and utilization of THWs;
1569-1570	Change	progress in reaching those benchmarks~~; and~~,
1571-1572	Change	CCOs shall establish, based on ~~recommendations~~OHA's and
1573	Deletion	and ~~standards issued by~~ the Traditional Health Worker Commission
1574	Insertion	Traditional Health Worker Commission guidelines, a
1575	Insertion	, a THW payment

1576	Deletion	payment ~~model~~ grid that
1577-1578	Change	grid that ~~defines~~includes alternative and sustainable
1579	Deletion	sustainable ~~THW payment levels and alternative~~ payment strategies.
1580-1581	Change	payment strategies. ~~The~~Each CCO shall
1582-1583	Change	CCO shall ~~make this payment model grid~~provide its THW Payment...Grid to make them publicly available.
1584	Deletion	Implemented: ORS 414.610 - 414.685
1585	Insertion	(1) Pursuant to OAR 410-141-
1586-1587	Change	Pursuant to OAR 410-141-~~380503~~3805, the Authority or Oregon Youth
1588-1589	Change	(~~1~~2) The Authority shall to the maximum
1590-1591	Change	authorizes disenrollment from a CCO~~.~~:
1592-1593	Change	consistent with OAR 410-141-3805~~.~~:
1594-1595	Change	(~~2~~3) When a child is transferred from
1596-1597	Change	consistent with OAR 410-141-3860~~.~~:
1598-1599	Change	continuous CCO enrollment for children~~.~~:
1600-1601	Change	adequate transition to the next CCO~~.~~:
1602-1603	Change	(~~3~~4) When a child experiences a change
1604-1605	Change	s service area~~.~~:
1606-1607	Change	the end of the temporary placement~~.~~:
1608-1609	Change	(b) Children receiving ~~CAF~~children, adult, and family services
1610-1611	Change	services ~~enroll~~from the Department who...eligible to be enrolled with the CCO serving the geographic
1612-1613	Change	the geographic area of placement~~. Child Welfare~~: Department representatives may request a service
1614-1615	Change	placement they consider temporary~~.~~:
1616-1617	Change	(c) Children in OYA custody ~~enroll~~who are eligible to be enrolled with the CCO serving the geographic
1618-1619	Change	the geographic area of placement~~.~~: OYA representatives may request

1620-1621	Change	(~~4~~5) If the Authority enrolls the child
1622	Insertion	services (PRTS), the CCO shall coordinate care and pay for covered health services
1623-1624	Change	s service area~~.~~;
1625-1626	Change	placement for purposes of CCO enrollment~~.~~;
1627-1628	Change	chapter 410, division 141 apply~~.~~;
1629-1630	Change	(~~5~~6) Except for OAR 410-141-3805 and
1631-1632	Change	for OAR 410-141-3805 and 410-141-~~3080~~3810, if a child is enrolled in a CCO
1633	Deletion	410-141-3805 Mandatory MCE
1634-1635	Change	410-141-3805 Mandatory MCE ~~Enrolment~~Enrollment Exceptions
1636	Deletion	(3) MCE enrollment is mandatory in~~-~~
1637	Deletion	(4) MCE enrollment is voluntary in~~-~~
1638-1639	Change	oral health services through an MCE~~.~~;
1640-1641	Change	(~~8~~9) Pursuant to ORS 414.631, the following
1642-1643	Change	(~~9~~10) In addition, the following enrollment
1644-1645	Change	(~~10~~11) Individuals who are documented
1646-1647	Change	(~~11~~12) A child in the legal custody of
1648-1649	Change	(~~12~~13) Clients who are dually eligible
1650-1651	Change	in aligning Medicare and Medicaid~~.~~;
1652-1653	Change	address or home geographic region~~.~~;
1654	Deletion	~~(i)~~
1655	Insertion	(i) The development of a prior-authorized
1656	Deletion	~~(ii)~~
1657	Insertion	(ii) Care management requirements based
1658-1659	Change	adequate health access and capacity~~.~~;
1660-1661	Change	(~~13~~14) The Authority may temporarily
1662-1663	Change	receive services on a FFS basis~~.~~;
1664	Deletion	clients with existing transplants ~~shall enroll into the...for their service area.~~
1665-1666	Change	~~(C) Other~~are not exempt from...there are other just causes to preserve
1667	Insertion	just causes to preserve the continuity of care
1668	Deletion	continuity of care ~~include the following:~~

1669	Deletion	~~(A) Enrollment poses a serious health risk; and~~
1670	Deletion	~~(B) The Authority finds...reasonable alternatives~~.
1671-1672	Change	(~~14~~15) MCE enrollment standards
1673-1674	Change	) MCE enrollment standards~~.~~;
1675-1676	Change	(~~e~~d) MCEs shall have open enrollment
1677-1678	Change	continuous calendar days during each ~~twelve~~12-month period of January through
1679-1680	Change	(~~15~~16) If
1681	Insertion	) If the Authority permits an MCE
1682-1683	Change	an MCE ~~is assumed by~~to assign its contract to another MCE, members shall be automatically
1684	Deletion	be automatically enrolled in the ~~succeeding~~ MCE
1685-1686	Change	MCE~~.~~ that has assumed the contract:
1687	Insertion	member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the
1688	Deletion	request disenrollment from the ~~succeeding~~ MCE
1689-1690	Change	MCE~~.~~ that has assumed the contract;
1691	Deletion	(b) If the ~~succeeding~~ MCE
1692	Insertion	MCE that has assumed the contract is a Medicare Advantage plan, those
1693-1694	Change	(~~16~~17) If an MCE engages in an activity
1695-1696	Change	required 90-calendar-day notice~~.~~;
1697	Deletion	(b) ~~If~~
1698	Moved to	The MCE shall provide...notice of such changes.
1699	Insertion	In the event the MCE is...providers or MCE, the Authority
1700-1701	Change	the Authority ~~must~~shall instead notify members of a change in participating
1702-1703	Change	participating providers or MCEs~~,~~. In such instances the MCE shall provide the Authority
1704	Moved from	effective date of such activity. ~~The MCE shall~~

		~~provide...notice of such changes.~~
1705	Deletion	410-141-3810 Disenrollment from
1706	Insertion	s representative. Some disenrollment...subsection of this rule.
1707-1708	Change	(b) ~~In accordance with 42 CFR 438.56(c)(2), the~~The Authority or MCE shall honor a
1709-1710	Change	(A) Without cause ~~(applies to MAGI and...410 division 200).~~:
1711	Insertion	change their MCE enrollment within 30 calendar days of the Authority
1712	Insertion	change their MCE enrollment within 90 calendar days of the initial MCE enrollment.
1713	Insertion	a plan for at least six months. If approved, the change...at the end of the month.
1714-1715	Change	to change their MCE enrollment ~~during~~at their OHP eligibility renewal
1716-1717	Change	OHP eligibility renewal~~, as defined in OAR...is typically 12 months~~. If approved, the change...at the end of the month.
1718	Deletion	the above options can be applied. ~~The plan change shall be..."recipient choice."~~ If
1719	Insertion	If a request for disenrollment is approved
1720	Insertion	approved under this section, the change would occur at the
1721	Deletion	would occur at the end of the month. ~~Once the recipient...additional plan change.~~
1722-1723	Change	(~~c~~B) With cause, at any time
1724-1725	Change	) With cause, at any time~~, if any of the following situations apply.~~ as follows:
1726	Insertion	(i) The member
1727	Moved to	moves out of the MCE service area;
1728	Insertion	or
1729-1730	Change	(~~A~~ii) Due to moral or religious objections
1731	Deletion	to moral or religious objections~~,~~ the
1732-1733	Change	the ~~MCE~~CCO does not cover the service the
1734-1735	Change	(~~B~~iii) When the member needs related
1736-1737	Change	related services (for example a

		~~cesarean~~Caesarean section and a tubal ligation) to
1738-1739	Change	(~~C~~D) Members who disenroll from a Medicare
1740-1741	Change	disenrolled from the corresponding ~~MCE~~CCO.
1742	Deletion	. ~~The effective date of...is effective.~~
1743-1744	Change	(~~D~~E) Other reasons including, but not
1745	Moved from	(i) The member ~~moves out of the MCE service area;~~
1746	Deletion	~~(ii) The member~~ is a Native American or Alaskan
1747-1748	Change	American or Alaskan Native with ~~Proof~~proof of Indian Heritage who wishes to
1749-1750	Change	(~~iii~~ii)
1751-1752	Change	) ~~Continuity of care that...as defined in this rule~~The member is at risk of...of continuity of care. Continuity of care for the purpose
1753	Deletion	necessary for a person's treatment. ~~Participation in OHP,...by a specific provider.~~ A request for disenrollment based
1754-1755	Change	the convenience or preference of ~~an OHP~~a member for a provider of a treatment,
1756-1757	Change	a treatment, service, or supply~~, including but not...with a provider;~~.
1758	Deletion	~~(d) Temporary enrolment~~
1759	Insertion	(I) A request for...CCO exemption.
1760	Insertion	(II) Authority decisions...hearing rights; and
1761	Insertion	(F) If 30 calendar
1762	Moved to	days pass without a...effective on the first
1763	Insertion	calendar
1764	Moved to	day of the following...before that date).
1765	Insertion	(c) A member may request a temporary enrollment exception during pregnancy
1766-1767	Change	exception during pregnancy~~.~~ as follows:
1768-1769	Change	(A) A temporary ~~enrolment~~enrollment request will be granted if
1770	Deletion	request will be granted if~~, as supported in 42 CFR 438.56(d)(2),~~ a member is at any point in

		the
1771	Insertion	newly determined eligible for OHP; or
1772-1773	Change	eligible for OHP and not enrolled in a ~~MCE~~CCO within the past three months; or
1774	Insertion	The member is enrolled with a new CCO MCE that does not contract with
1775	Insertion	shall remain in place until 60 calendar days postdate of
1776	Insertion	days postdate of either the delivery of the member
1777	Insertion	s child or the pregnancy otherwise ends, at which time the member shall
1778	Deletion	at which time the member shall ~~select and~~ be enrolled in the appropriate
1779-1780	Change	be enrolled in the appropriate ~~MCE plan~~CCO in their service area.
1781	Insertion	in their service area. Where there is a choice...a next weekly basis.
1782-1783	Change	(~~e~~d)
1784-1785	Change	) ~~Member~~Upon approval of a member's disenrollment
1786	Deletion	disenrollment ~~requests under this...following requirements.~~
1787-1788	Change	~~(A) The member~~from a CCO, the Member shall join another
1789-1790	Change	shall join another ~~MCE~~CCO unless
1791-1792	Change	unless ~~the~~:
1793	Insertion	(A) The member resides in a service area
1794-1795	Change	area where enrollment is voluntary~~,~~; or
1796	Deletion	or ~~the~~
1797	Insertion	(B) The member meets the exemptions to
1798-1799	Change	enrollment set forth in OAR 410-141-3805~~,~~; or
1800	Deletion	or ~~the~~
1801	Insertion	(C) The member meets disenrollment criteria
1802-1803	Change	disenrollment criteria stated in ~~42 CFR 438.56(c)(2), or there~~this rule; or
1804	Insertion	(D) There is not another

1805-1806	Change	is not another ~~MCE~~CCO available and open to new enrollment in the service area.
1807	Deletion	~~(B) If 30~~
1808-1809	Moved from	~~days pass without a...effective on the first day of the following...before that date).~~
1810	Deletion	~~(a) Subject to applicable...the following scenarios:~~
1811	Deletion	~~(A) The member commits~~
1812	Insertion	(a) MCEs may request...(G) below.
1813	Insertion	(A) If the member is...to the hospital, the CCO
1814	Moved to	shall be responsible for...care (PHEC) benefit
1815	Insertion	. If the member is...enrolled with a CCO;
1816	Insertion	(B) If the CCO
1817	Moved to	determines the member...Liability (TPL), the
1818	Insertion	CCO shall report the TPL to the Authority's
1819	Moved to	Health Insurance Group (HIG)
1820-1822	Insertion	on the webform located at https://w...hig.aspx. The CCO shall receive...online report. The CCO
1823	Moved to	may use this number,...the member from the
1824	Insertion	CCO effective at the end...the TPL is reported
1825	Moved to	. In some situations, the...disenrollment
1826	Insertion	;
1827	Insertion	(C) If a member has been residing outside
1828	Moved to	the MCE's service area...with the MCE. The
1829	Insertion	MCE shall provide...If approved, the
1830	Moved to	effective date of...payment from the MCE
1831	Insertion	;
1832	Insertion	(D) If the
1833	Moved to	member is an inmate who...in a facility
1834	Insertion	before or
1835	Moved to	after their case has been...and provide sufficient
1836	Insertion	written
1837	Moved to	proof of incarceration to...The effective date
1838	Insertion	of any disenrollment approved by the Authority.

1839	Moved to	shall be the date the member was incarcerated
1840	Insertion	:
1841	Insertion	(E) If, prior to January...institution; or
1842	Insertion	(F
1843	Moved to	) The Medicare member is...enrollment in the MCE.
1844	Moved to	(
1845	Insertion	G
1846	Moved to	) The member had End...enrollment in the MCE.
1847	Insertion	(3) MCE Disenrollment...or Illegal Acts.
1848	Insertion	(a) MCEs have the right...members when they commit fraudulent or illegal acts related
1849	Deletion	fraudulent or illegal acts related to ~~the member's~~ participation in the OHP such as:
1850	Insertion	(b) The MCE shall report any illegal
1851	Deletion	the DHS Fraud Investigations Unit~~, consistent with 42 CFR 455.13~~.
1852	Deletion	(~~B) The member is...needs or disability.~~
1853-1854	Change	~~(b) Routine~~c) When requesting disenrollment
1855	Deletion	disenrollment ~~for reasons other than an...of this subsection (b).~~
1856-1857	Change	~~(A) The MCO~~based on a member's...illegal act(s), the MCE shall submit a written disenrollment
1858	Insertion	written disenrollment request to its CCO AR at the
1859-1860	Change	the ~~Coordinated Account Representative (CAR). The~~Authority. In the disenrollment request, the MCE shall document the reasons
1861-1862	Change	support the basis for the request, ~~and document that...made as described below~~including any...Investigations Unit.
1863	Deletion	~~(i) There shall be...describe the problem and~~
1864	Moved from	~~allow time for appropriate resolution by the MCE~~
1865	Deletion	~~. Such notification shall...or training regarding~~

1866	Moved from	~~the need for early...accommodation, and the~~
1867	Deletion	~~services available to the provider;~~
1868	Deletion	~~(ii) The MCE shall...from the MCE;~~
1869	Deletion	~~(iii) The MCE shall provide~~
1870	Moved from	~~individual education,...or other interventions~~
1871	Deletion	~~with the member in a...to resolve the problem;~~
1872	Deletion	~~(iv) The MCE shall...confidentiality;~~
1873	Deletion	~~(v) If the severity of...with the member, their~~
1874	Moved from	~~care team, and other...chosen by the member~~
1875	Deletion	~~. If necessary, the MCE...in the member's record;~~
1876	Deletion	~~(c) The MCE shall submit...by the Authority CAR.~~
1877	Deletion	~~(d) The Authority shall...routine disenrollment.~~
1878	Deletion	~~(e) Routine disenrollment...each of the following:~~
1879	Insertion	(d) Based on the evidence...fraud investigation.
1880	Insertion	(4) MCE Disenrollment...or Disruptive Behavior.
1881	Insertion	(a) Subject to applicable...purposes of this rule.
1882-1883	Change	(~~A~~b)
1884-1885	Change	) ~~A written description of...s behavior poses~~For purposes of this rule, a
1886	Insertion	a "direct threat
1887-1888	Change	direct threat~~ to the health or safety of others. Direct threat~~" means a significant risk to the
1889	Insertion	on current medical knowledge or the best available objective evidence
1890-1891	Change	shall mitigate the risk to others~~;~~.
1892	Deletion	~~(B) A MCE-staffed~~
1893	Insertion	(c) MCEs shall not have...the following reasons:
1894	Insertion	(A) Physical
1895	Moved to	, intellectual,...or mental disability;
1896	Insertion	or

1897	Insertion	(B) An adverse change in the member's health; or
1898	Insertion	(C) Under or over-utilization of services; or
1899	Insertion	(D) Filing a grievance or...case hearing rights; or
1900	Insertion	(E) The
1901	Moved to	member exercises their...the MCE disagrees; or
1902	Moved to	(
1903	Insertion	F) Uncooperative
1904	Moved to	or disruptive behavior...member's special needs.
1905	Moved to	(
1906	Insertion	d) MCEs shall require...(5) of this rule.
1907	Moved to	allow time for appropriate resolution by the MCE
1908	Insertion	before refusing to...medical record.
1909	Insertion	(e) In response to...for disenrollment:
1910	Insertion	(A) Furnish education and...notifying provider about
1911	Moved to	the need for early...accommodation, and the
1912	Insertion	resources or services...the reporting provider.
1913	Insertion	(B) Contact the member...member, the MCE shall:
1914	Insertion	(i) Inform the member of...regarding the behavior;
1915	Insertion	(ii) Advise the member...to participate in
1916	Moved to	individual education,...or other interventions
1917	Insertion	in an effort to resolve the behavior; and
1918	Insertion	(iii) Inform the member...from the MCE.
1919	Insertion	(C) In the event the...member, member focused
1920	Moved to	care team, and other...chosen by the member
1921	Insertion	with appropriate releases documented.
1922	Insertion	(D) In the event the...the MCE shall convene an interdisciplinary team
1923	Deletion	interdisciplinary team ~~review~~ that includes a

		mental health professional
1924	Deletion	care professionals who have the ~~appropriate~~ clinical expertise
1925-1926	Change	clinical expertise ~~in treating~~necessary for reviewing and assessing the member
1927	Deletion	s ~~condition to assess the~~ behavior,
1928-1929	Change	behavior, ~~the~~their behavioral history, and previous
1930	Deletion	behavioral history, and previous ~~history of~~ efforts
1931	Insertion	efforts undertaken to manage
1932	Insertion	to manage the member's behavior
1933	Deletion	behavior~~;~~
1934-1935	Change	~~(C) If warranted, a...of whether the~~, including those...or disruptive behavior
1936-1937	Change	behavior ~~will respond to~~through other reasonable clinical or social interventions
1938-1939	Change	clinical or social interventions~~;~~.
1940	Deletion	~~(D) Documentation of any~~
1941	Insertion	(f) All efforts...member's medical record.
1942	Insertion	(g) If, after undertaking...all of the following:
1943	Insertion	(A) Sets forth the...at intervention and accommodations that
1944-1945	Change	accommodations that ~~have been attempted and why the~~were made, why those interventions and accommodations
1946-1947	Change	accommodations ~~haven't worked;~~were not effective, and...(4) of this rule.
1948	Deletion	~~(E) Documentation of~~
1949	Insertion	(B) Identifies, and...may have and describes:
1950	Insertion	(i) The relationship the...needs or disability; and
1951	Insertion	(ii) Why the MCE has...needs or disability.
1952	Insertion	(C) States whether the...or safety of others.
1953	Insertion	(D) Identifies the documentation that supports the MCE
1954-1955	Change	ability to furnish services to either ~~this~~

		~~particular~~the member
1956-1957	Change	member ~~or~~who has engaged in the...behavior or the MCE's other members
1958-1959	Change	other members~~;~~.
1960	Deletion	~~(F~~
1961	Insertion	(E) Provide written...also enrolled in the CCO
1962	Moved to	's Medicare Advantage plan
1963	Insertion	.
1964	Insertion	(F) Furnish all other...by the MCE's CCO AR.
1965	Insertion	(h) If a Primary Care Provider (PCP)
1966	Insertion	the provider/patient relationship during the period of...in this section (4), the
1967-1968	Change	, the ~~MCE~~CCO shall
1969	Insertion	shall, prior to submitting a...for disenrollment, attempt to locate another
1970	Insertion	attempt to locate another participating PCP
1971	Deletion	PCP ~~on their panel~~ who
1972-1973	Change	who ~~shall~~will accept the member as their patient.
1974-1975	Change	as their patient. If needed, the ~~MCE~~CCO shall obtain an authorization for
1976-1977	Change	information necessary for a new ~~provider~~PCP to evaluate whether they can treat
1978-1979	Change	relationships shall be consistent with the ~~MCE~~CCO
1980-1981	Change	s OHP policies, the ~~MCE~~CCO or PCP
1982	Deletion	disability discrimination laws. ~~The~~
1983	Insertion	(5) MCE
1984	Deletion	MCE ~~shall determine whether...discrimination laws.~~
1985-1986	Change	~~(f)~~Disenrollment Requests
1987-1988	Change	Requests ~~by~~: Credible Threats of Violence.
1989	Insertion	(a) MCEs have the
1990-1991	Change	the ~~MCE for~~right to request an exception to the
1992-1993	Change	an exception to the ~~routine~~MCE initiated disenrollment

1994	Deletion	disenrollment ~~process shall, to the...comply with the~~ requirements
1995	Deletion	requirements ~~set forth above in...following requirements:~~
1996-1997	Change	~~(A) In accordance with 42...for members who have~~outlined in section (4)...rule when a member has committed an act of, or made a
1998	Deletion	staff, other patients, or the MCE~~'s~~ staff
1999	Insertion	staff, so that it seriously impairs the
2000	Insertion	particular member or other members .__
2001-2002	Change	(~~referred to below as "the incident"). A~~b) For purposes of this rule, a credible threat means that there
2003	Deletion	may cause grievous physical injury ~~to others~~ (including but not limited to death)
2004	Deletion	policies, practices, or procedures. ~~The MCE~~
2005	Insertion	(c) MCEs shall
2006-2007	Change	shall ~~document the reasons for...provide written evidence~~require their providers to
2008-2009	Change	to ~~support~~notify both the
2010	Deletion	the ~~basis for the request,...as described below.~~
2011-2012	Change	~~(i) Providers shall~~MCE and law enforcement immediately
2013-2014	Change	immediately ~~notify the MCE about the incident with the member~~when a member has acted...of physical violence.
2015	Insertion	(A) The notification
2016	Insertion	The notification may be made to the MCE...notice to the MCE.
2017	Insertion	(B) Notice under this subsection (c) shall describe the
2018-2019	Change	shall describe the ~~problem and shall be...documentation purposes;~~circumstances surrounding...provider as a result.
2020-2021	Change	(~~ii~~C)
2022-2023	Change	) ~~The MCE~~MCEs shall
2024-2025	Change	shall ~~attempt, and~~require their providers to

		document
2026-2027	Change	document ~~contact with~~the incident in the member
2028	Insertion	the member's medical record and
2029-2030	Change	and ~~their~~the MCE shall document...the member's case file.
2031	Insertion	(d) The MCE shall notify the member's care team
2032-2033	Change	care team ~~regarding~~of the
2034-2035	Change	the ~~problem and, if needed,~~act or credible threat of violence. The MCE shall involve the
2036	Insertion	involve the member's care team and
2037	Moved from	care team and ~~other appropriate individuals~~
2038-2039	Change	~~in the resolution~~, within the laws governing confidentiality
2040	Deletion	the laws governing confidentiality~~;~~
2041	Deletion	~~(iii) If the member's...the risk to others.~~
2042	Deletion	~~(iv) The MCE shall...following documentation:~~
2043-2044	Change	~~(I) Documentation that...The MCE shall submit~~,
2045	Moved to	other appropriate individuals
2046	Insertion	which may include,...s violent behavior.
2047	Insertion	(e) The MCE and the care...threat of violence.
2048	Insertion	(f) If the MCE determines...for disenrollment.
2049	Insertion	(g) If the MCE determines...as follows:
2050	Insertion	(A) Include an...physical violence; and
2051	Insertion	(B) In addition to all...must also include a copy of the police report or
2052	Insertion	police report or case number. If a police report
2053	Insertion	report or case number is not available, the MCE shall
2054-2055	Change	available, the MCE shall submit a ~~signed~~copy of the provider's entry in the member
2056-2057	Change	s ~~clinical~~ medical record
2058	Deletion	record ~~documenting the report...reasonable evidence.~~
2059	Deletion	~~(II) Documentation that...the risk to others.~~

2060	Deletion	~~(H) Documentation that...with this member.~~
2061	Deletion	~~(I) Documentation that...member or other members.~~
2062	Deletion	~~(B) The MCE shall provide...assessment team;~~
2063	Deletion	~~(g) Approval or denial of...disenrollment requests.~~
2064	Deletion	~~(A) If there is...the request shall~~
2065	Moved from	~~be evaluated by the MCE's~~
2066	Deletion	~~CAR or a team of CARs who...use disorder specialist.~~
2067	Moved from	~~(B) In cases where the member~~
2068	Deletion	~~is also enrolled in the MCE~~
2069	Moved from	~~'s Medicare Advantage plan~~
2070-2071	Change	~~, the MCE shall provide...date approved by CMS.~~, which must be signed by...reasonable evidence.
2072	Insertion	(6) Approval or Denials...Threats of Violence.
2073	Insertion	(a) MCE requests made...rule shall be denied.
2074-2075	Change	(~~C~~A)
2076-2077	Change	) ~~If~~When there is insufficient documentation
2078	Insertion	there is insufficient documentation submitted with a request for disenrollment, the
2079-2080	Change	, the ~~CAR~~CCO AR shall notify the MCE
2081	Insertion	shall notify the MCE of the denial within two business days of
2082	Insertion	within two business days of the initial
2083-2084	Change	initial ~~receipt what supporting...of the request.~~request.
2085	Insertion	(B) MCEs may submit a new...provided to the CCO AR.
2086	Insertion	(b) After receipt of a...the request will
2087	Moved to	be evaluated by the MCE's
2088	Insertion	CCO AR and relevant...review team).
2089	Deletion	~~(D) The CARs shall review...days of receipt of~~
2090	Insertion	(c) The CCO AR will...review team.
2091	Insertion	(A) The CCO AR shall...of the affected member.

2092	Insertion	(B) The documentation...certification, or both.
2093	Insertion	(C) The decision, and all...maintained by OHA.
2094	Insertion	(d) The CCO AR shall...OHA Medicaid Director.
2095	Insertion	(A) All notices of...in the notice.
2096	Insertion	(B) When there is sufficient documentation
2097-2098	Change	sufficient documentation ~~from~~for the
2099	Deletion	the ~~MCE.~~
2100-2101	Change	~~(E) Written decisions~~CCO AR to convene a...for disenrollment shall be
2102-2103	Change	shall be ~~sent to~~made by the
2104-2105	Change	the ~~MCE~~Authority within 15
2106-2107	Change	within 15 ~~working~~business days
2108-2109	Change	days ~~from~~of receipt of
2110	Insertion	receipt of the request
2111-2112	Change	request ~~and sufficient documentation from the CAR~~for disenrollment.
2113	Deletion	~~(h) The following...made by the MCE:~~
2114	Deletion	~~(A) The CAR~~
2115	Insertion	(e) The CCO AR shall
2116-2117	Change	shall ~~send~~provide the
2118	Insertion	the affected member
2119-2120	Change	member ~~a~~with written notice
2121	Insertion	notice of their disenrollment within five
2122	Insertion	within five business days after the
2123-2124	Change	days after the ~~request was~~Authority has approved
2125-2126	Change	approved ~~with a copy~~the MCE's request for...notice shall be sent to the MCE
2127-2128	Change	to the MCE ~~and~~, which the MCE shall distribute to the member
2129	Insertion	s care team. A copy of the member...following information:
2130	Insertion	(A) The disenrollment date;
2131	Deletion	(B) The ~~notice shall give the disenrollment date, the~~ reason for disenrollment

2132-2133	Change	reason for disenrollment~~, and the notice of~~;
2134	Insertion	(C) Information regarding the member
2135-2136	Change	s right to file a ~~complaint as specified in...through 410-141-3905~~grievance and
2137-2138	Change	and ~~to request an~~their administrative hearing
2139	Insertion	administrative hearing rights; and
2140	Deletion	and ~~the option to continue...pending a decision;~~
2141	Insertion	(D) All applicable...member's care team.
2142-2143	Change	(~~C~~f) The
2144	Insertion	) The date of disenrollment
2145	Insertion	disenrollment shall be effective
2146	Deletion	effective ~~date shall be~~ ten calendar days after the
2147	Insertion	ten calendar days after the date of the member's disenrollment notice
2148	Deletion	disenrollment notice ~~is sent to the member~~, unless
2149-2150	Change	, unless ~~the~~:
2151	Insertion	(A) The member
2152	Insertion	member files a grievance or otherwise requests a hearing
2153-2154	Change	requests a hearing ~~and ongoing enrollment...a hearing decision. The~~, in which case...Upon final decision by
2155	Moved to	an administrative law judge
2156	Insertion	to uphold the Authority...the member's disenrollment shall become effective
2157	Deletion	become effective immediately upon ~~the issuing of~~
2158	Moved from	~~an administrative law judge~~
2159-2160	Change	~~'s decision to uphold disenrollment~~such decisions;
2161	Insertion	; or
2162	Deletion	~~(i) If disenrollment is...with another MCE;~~
2163	Deletion	~~(ii) If no other MCE is...team for review.~~
2164	Deletion	~~(3) Other reasons for...request disenrollment:~~

2165	Deletion	~~(a) If the member is...to the hospital, the MCE~~
2166	Moved from	~~shall be responsible for...care (PHEC) benefit~~
2167	Deletion	~~, as provided in...hospital services.~~
2168	Deletion	~~(b) The member has...by that provider.~~
2169	Deletion	~~(c~~
2170	Moved from	~~) The Medicare member is...enrollment in the MCE.~~
2171	Moved from	~~(~~
2172	Deletion	~~d) If the MCE~~
2173	Moved from	~~determines the member...Liability (TPL), the~~
2174	Deletion	~~MCE shall report the TPL to the~~
2175	Moved from	~~Health Insurance Group (HIG)~~
2176	Deletion	~~and HIG send the MCE an...tracking number. The MCE~~
2177	Moved from	~~may use this number,...the member from the~~
2178	Deletion	~~MCE A or B, effective the...that month's 834 report~~
2179	Moved from	~~. In some situations, the...disenrollment~~
2180	Deletion	~~.~~
2181	Deletion	~~(e) Members shall be disenrolled if out of~~
2182-2183	Moved from	~~the MCE's service area...with the MCE. The effective date of...payment from the MCE~~
2184	Deletion	~~.~~
2185	Deletion	~~(f) The~~
2186-2189	Moved from	~~member is an inmate who...in a facility after their case has been...and provide sufficient proof of incarceration to...The effective date shall be the date the member was incarcerated~~
2190	Deletion	~~.~~
2191	Deletion	~~(g) If, prior to Contract...psychiatric institution;~~
2192	Deletion	~~(h~~
2193	Moved from	~~) The member had End...enrollment in the MCE.~~
2194	Deletion	~~(4) The MCE may not...the following reasons:~~
2195	Deletion	~~(a) Because of a physical~~

2196	Moved from	~~, intellectual,...or mental disability;~~
2197	Deletion	~~(b) Because of an adverse...in the member's health;~~
2198	Deletion	~~(c) Because of the member...or lack thereof;~~
2199	Deletion	~~(d) Because the member requests a hearing;~~
2200	Deletion	~~(e) Because the~~
2201	Moved from	~~member exercises their...the MCE disagrees; or~~
2202	Moved from	~~(~~
2203	Deletion	~~f) Because of uncooperative~~
2204	Moved from	~~or disruptive behavior...member's special needs.~~
2205	Moved from	~~(~~
2206	Deletion	~~5) If a member's...does not include:~~
2207	Deletion	~~(a) Involuntary transfer...one MCE to another; or~~
2208	Deletion	~~(b) Automatic enrollment of a member in a MCE.~~
2209	Moved to	(B) In cases where the member
2210	Insertion	had a CCO aligned...Plan approved by CMS.
2211	Insertion	(7) Enrollment for...Approved Disenrollment.
2212	Insertion	(a) When circumstance...member's residence; or
2213	Insertion	(b) When circumstances...an appropriate MCE; or
2214	Insertion	(c) When no alternative...for the member.
2215-2216	Change	(~~6~~8) Unless specified otherwise in
2217	Insertion	specified otherwise in these rules, or in the Authority notification
2218-2219	Change	of disenrollment to the MCE, all ~~disenrollment's~~disenrollments are effective the end of the month
2220	Insertion	enrollment shall be the date of the member's death.
2221-2222	Change	(~~7~~9) Transfers of 500 or more members.
2223	Insertion	contracted with the receiving MCE and the provider has stopped accepting patients from

2224	Insertion	stopped accepting patients from the MCE from which the...is being transferred, or has terminated providing services
2225-2226	Change	terminated providing services to members ~~in~~who are enrolled with the
2227	Deletion	the ~~transferring~~ MCE
2228	Insertion	MCE from which the member is being transferred;
2229-2230	Change	(b) The transfer shall ~~take effect when~~become effective the date on which the provider
2231-2232	Change	contract with their current MCE ~~contractual relationship ends~~terminates or otherwise expires, or on
2233-2234	Change	, or on ~~a~~another date approved by the Authority.
2235-2236	Change	(c) Members ~~may~~shall not be transferred under this section
2237-2238	Change	transferred under this section (~~8~~9) unless the following conditions
2239	Insertion	receiving MCE and determined that the receiving MCE meets criteria established by
2240-2241	Change	established by the Authority as stated in ~~rule~~OAR 410-141-3705 including, but not limited to,
2242	Insertion	affected by the transfer at least 90 calendar days before the scheduled date
2243	Insertion	414.615, 414.625, 414.635 & 414.651, 42 CFR 438.56, 42 CFR 455.13, 42 CFR 438.420
2244-2245	Change	Statutes/Other Implemented: ORS 414.610 - ~~414.685~~414.68
2246	Insertion	
2247	Deletion	410-141-3815 CCO Enrollment for
2248	Deletion	(1~~) For purposes of this...definitions apply:~~
2249	Deletion	~~(a)~~
2250	Moved from	~~"Home CCO" means the CCO...on permanent residency.~~
2251	Deletion	~~(b~~
2252	Moved from	~~) "Permanent Residency"...to after placement~~

		ends.
2253	Moved from	(
2254	Deletion	c
2255-2256	Moved from	) "Temporary Placement" means hospital, institutional,...Home CCO service area.
2257	Moved from	(
2258	Deletion	2) The Authority has determined that,
2259-2260	Change	behavioral health treatment services.;
2261-2262	Change	410-141-3800 for program-specific rules.;
2263-2264	Change	managing admissions and discharges.;
2265-2266	Change	(32) Specific to residential settings
2267	Insertion	individual is enrolled in a CCO or FFS on the same day the individual is
2268	Insertion	residential treatment services, the CCO or FFS shall be responsible for the covered
2269-2272	Change	s service area. The individual is...be enrolled in the CCOUpon discharge, FFS...upon the next weekly enrollment period, enroll with
2273	Deletion	with which the
2274-2275	Change	the individual was most recently enrolledCCO that is contracted...residential service area.
2276-2277	Change	(43) Home CCO assignment is based on
2278-2279	Change	(54) Home CCO enrollment policy for
2280-2281	Change	the Home CCO for client placement.;
2282-2283	Change	(65) For new and existing temporary
2284-2285	Change	non-emergent physical health care, dentaloral, and transportation when within
2286-2287	Change	(76) Enrollment shall follow the Home
2288-2289	Change	(87) Pursuant to OAR 410-141-3810,
2290-2291	Change	(98) For consideration of disenrollment
2292	Deletion	410-141-3820
2293	Deletion	410-141-3820 Covered Services (Revised 8/2/19)
2294	Deletion	Benefit Package includes treatments paired with conditions and
2295	Insertion	and health services
2296-2297	Change	services specified by Statements...which are

		~~included in~~which pair together with a condition on the
2298-2299	Change	the ~~funded portion~~same line of the Health Evidence Review Commission
2300	Insertion	Services adopted under OAR 410-141-3830, to the extent that such...List of Health Services. The Benefit Package also covers
2301-2302	Change	410-141-3820 and 410-141-3825, the word "~~service~~health services" has the meaning given in ORS 414.025(13)
2303	Insertion	meaning given in ORS 414.025(13);
2304-2305	Change	when the services are medically or ~~dentally~~orally necessary and appropriate as defined
2306-2307	Change	prudent layperson standard defined in ~~410-141-3840.~~ ORS 743A.012;
2308-2309	Change	is discussed in OAR 410-141-3855~~.~~;
2310-2311	Change	(2) MCE service offerings~~.~~;
2312-2313	Change	(b) CCOs shall ~~integrate~~coordinate physical health, behavioral health
2314-2315	Change	health and oral health care benefits~~.~~;
2316	Insertion	services. Diagnostic services that are medically or orally...and medically or orally necessary
2317	Deletion	necessary ~~and reasonable~~ to diagnose the member
2318	Insertion	appears above or below the funded line on the Prioritized List...Diagnostic Guidelines on the Prioritized List of Health
2319-2320	Change	Preventive services. Preventive ~~services~~Services are
2321-2322	Change	are ~~covered if they appear~~included in the OHP benefit package as described in the funded portion of the Prioritized
2323	Insertion	Prioritized List of Health Services, as specified in related guideline notes. These services include, but are
2324-2325	Change	(a) The services are medically or ~~dentally~~orally necessary and appropriate in order

2326	Insertion	capability for independence or self-care;
2327	Insertion	(c) Coverage of ancillary...List of Health Services.
2328-2329	Change	effect on funded comorbid conditions.;
2330-2331	Change	for coverage under subsection (8)10)
2332-2333	Change	).;
2334-2335	Change	disorder, represented by a DSM diagnosis.;
2336	Insertion	(B) Medical research; and
2337	Deletion	(C) Community standards; and
2338	Deletion	(D
2339	Insertion	(C) Current peer review.
2340-2341	Change	coverage options are considered.;
2342-2343	Change	comorbid condition under subsection (8).;
2344-2345	Change	indicators that would warrant a repeat diagnosticevaluation visit.
2346-2347	Change	information line for the purpose of providing assistance toassisting practitioners in determining coverage
2348	Insertion	pertaining to a funded condition and a funded
2349	Insertion	funded or unfunded treatment that
2350-2351	Change	treatment that dodoes not pair
2352	Insertion	not pair with the same condition on the HERC Prioritized List of
2353	Insertion	Prioritized List of Health Services, and coverage is not otherwise available
2354-2355	Change	otherwise available pursuant to this section,rule, or excluded by any applicable statute, and the member
2356-2357	Change	the member's requests an appeal from their MCE
2358	Deletion	MCE —or
2359-2360	Change	or fora hearing from fee for service, the
2361-2362	Change	fee for service, the medical review unit may seek a coverageMCE or Division must make an ad hoc determination
2363-2364	Change	determination from the Divisionon an individual basis as...for the member;

2365	Insertion	(b) If the member requests a hearing the Division determines
2366-2367	Change	Division determines ~~that~~whether the HERC has
2368	Moved from	HERC has ~~not~~ considered the funded condition/treatment
2369	Insertion	inclusion on the Prioritized List within the last five years. If the HERC has
2370	Moved to	not
2371	Insertion	considered the pair for...the last five years, the Division shall make an ad
2372	Insertion	determination in consultation with the HERC:
2373	Insertion	(A) If the Division...determinations:
2374	Insertion	(i) Is the condition...of Health Services;
2375	Insertion	(ii) Is the treatment on...funded or unfunded;
2376	Insertion	(iii) Is the treatment...for the member; and
2377	Insertion	(iv) Has the HERC...it is not covered.
2378	Insertion	(B) If the Division...then proceed to hearing;
2379	Insertion	(C) If the Division...then proceed to hearing;
2380	Insertion	(D) If the Division...to proceed to hearing.
2381-2382	Change	(c) If ~~an MCE disagrees with the~~a Division
2383	Insertion	Division hearing overturns a MCE
2384-2385	Change	(14) General anesthesia for ~~dental~~oral procedures. General anesthesia
2386-2387	Change	procedures. General anesthesia for ~~dental~~oral procedures that are medically and
2388-2389	Change	procedures that are medically and ~~dentally~~orally necessary and appropriate to be
2390	Deletion	410-141-3825 Excluded Services and
2391	Deletion	Excluded Services and Limitations ~~(Revised 8/2/19)~~
2392-2393	Change	(b) Any service identified in ~~the appropriate~~applicable provider guides as a non-covered
2394	Insertion	coverage rules in OAR 410-141-3820:
2395-2396	Change	(A) ~~Authorized~~Ordered or referred by the client
2397-2398	Change	pursuant to rule or the MCE contract~~.~~:

2399	Insertion	(D) This exclusion does not apply if
2400	Insertion	that are medically appropriate and necessary to
2401	Deletion	to: provide reasonable diagnosis and
2402	Deletion	diagnose a presenting problem, whether or not the resulting diagnosis and indicated
2403	Deletion	410-141-3830 Prioritized List of
2404-2405	Change	the most current list on their websitehttpswebsite: https://www.oregon.gov/OHA/HPA/
2406-2407	Change	://www.oregon.gov/OHA/HPA/CSIDSI-HERC/ Pages/Prioritized-List.aspx.
2408	Insertion	-HERC/Pages/Prioritized-List.aspx. For a hard copy, contact the Division within the Oregon Health Authority
2409	Insertion	Authority (Authority).
2410-2411	Change	This rule, effective January 1, 20192020, incorporates by reference new
2412-2413	Change	that supersede those found in the OctoberJanuary 1,
2414-2415	Change	1, 20182019, Prioritized List.
2416-2417	Change	Statutory/Other Authority: ORS 413.042 &and ORS 414.065
2418-2419	Change	Statutes/Other Implemented: ORS 414.065 &and ORS 414.727
2420	Deletion	410-141-3835 MCE Service Authorization
2421	Deletion	410-141-3835 MCE Service Authorization (Revised 8/2/19)
2422-2423	Change	set forth in OAR 410-141-3885. MCESMCEs shall observe required timely access
2424-2425	Change	ongoing or chronic conditions or requirethose conditions requiring long-term services and supports
2426	Insertion	used consistent with 42 CFR §441.20 and the member's free...and 42 CFR §431.51; and
2427	Insertion	individual or entity to deny, limit, delay, or discontinue medically necessary
2428	Deletion	(B) For notices of actions/adverse benefit

		determinations that
2429-2430	Change	shall mail the notice at least ~~ten~~10 days before the date the adverse
2431	Insertion	receipt of the request for service, which period of time...receipt of the request;
2432	Insertion	requested to the member, pharmacy, and prescribing practitioner; or
2433	Insertion	determination of the drug to the member, and telephonic or electronic notice to the pharmacy and
2434	Insertion	pharmacy and the prescribing practitioner if the
2435-2436	Change	decision begins with the initial date~~/~~ and time stamp of a prior authorization
2437-2438	Change	authorization request for a drug~~.~~;
2439-2440	Change	later than 72 hours from the date~~/~~ and time
2441	Insertion	time stamp of the initial request for prior
2442-2443	Change	the MCE shall notify the member~~,~~ in writing and the pharmacy and prescribing practitioner
2444	Deletion	pharmacy and prescribing practitioner ~~in writing,~~ telephonically
2445	Insertion	telephonically, or electronically; or
2446	Insertion	benefit determination to the member, and telephonic or electronic notice to the pharmacy and
2447	Insertion	pharmacy and the prescribing practitioner
2448-2449	Change	prescribing practitioner~~; and~~,
2450-2451	Change	received within 72 hours from the date~~/~~ and time
2452	Insertion	time stamp of the initial request for prior
2453	Insertion	benefit determination to the member, and telephonic or electronic notice to the pharmacy and prescribing practitioner.
2454-2455	Change	member's health condition requires~~.~~;
2456	Insertion	(i) Date and time stamping prior authorization requests
2457	Deletion	410-141-3840 Emergency and Urgent
2458-2459	Change	provider provides a medically or ~~dentally~~orally

		appropriate response as indicated
2460	Insertion	or emergency calls including but not limited to the following:
2461-2462	Change	Provision for notifying other providers~~, when necessary, to...to treat members~~ that prior authorization...with this rule.
2463	Insertion	notified, or because the CCO was not timely billed
2464-2465	Change	billed ~~within ten calendar days of~~for the service.
2466-2467	Change	and emergency care settings for ~~dental~~oral health care
2468-2469	Change	health care~~.~~;
2470	Insertion	CCOs shall educate members about, and support them in, how to appropriately access care
2471	Deletion	410-141-3845 Health-Related Services
2472-2473	Change	to covered health care services~~.~~;
2474-2475	Change	as those terms are defined below~~:~~;
2476-2477	Change	satisfy the requirements of this rule~~.~~;
2478	Insertion	the complete discretion of the CCO;
2479	Insertion	(d) HRS may be used to...or tribal-based services.
2480-2481	Change	following requirements, consistent with ~~42~~45 C.F.R. § 158.150:
2482-2483	Change	submitted to the Authority for approval~~.~~;
2484-2485	Change	barriers, and provide for accountability~~.~~;
2486-2487	Change	community benefit initiatives shall ~~align~~promote alignment with the priorities identified
2488-2489	Change	community health improvement plan~~. CCOs will align~~, and with any HRS community benefit
2490-2491	Change	HRS community benefit ~~initiatives spending with any HRS CBI~~initiative spending priorities identified
2492-2493	Change	priorities identified by the Authority~~.~~;
2494	Insertion	the role of the CAC and tribes in community

		benefit initiatives spending decisions
2495-2496	Change	spending decisions~~.~~:~~.~~
2497-2498	Change	(d) ~~MCEs~~CCOs shall not limit the range of permissible
2499	Insertion	offered to an individual member as an adjunct to
2500	Deletion	to ~~supplement~~ covered benefits. Flexible services
2501-2502	Change	treatment plan and clinical record~~.~~:~~.~~
2503	Insertion	(a)
2504	Moved to	CCOs shall provide...on the member's behalf
2505	Insertion	.
2506	Moved to	The written notification...response to the outcome
2507	Insertion	.
2508-2509	Change	(~~a~~b) A CCO
2510	Moved from	and OAR 410-141-3835 through 3915. ~~CCOs shall provide...on the member's behalf~~
2511	Deletion	~~;~~
2512	Deletion	~~(b)~~
2513	Moved from	~~The written notification...response to the outcome~~
2514	Deletion	~~.~~
2515	Deletion	~~(a)~~ CCOs shall designate a role for
2516	Deletion	initiatives, as provided in OAR 410-141-~~AAAA [new SDOH-HE rule].~~
2517-2518	Change	~~(b) Community benefit...plan or clinical record~~3735.
2519	Deletion	410-141-3850 Transition of Care
2520-2521	Change	does not apply to a member who is ~~disenrolled from~~ineligible for Medicaid or who has a gap in coverage
2522	Insertion	(C) Prescription drugs; and
2523-2524	Change	(~~C~~D) Care coordination, as defined
2525	Insertion	(b) "Medically Fragile...of Human Services (DHS);
2526	Insertion	(c) "Prior Authorized Care" means

2527-2528	Change	approved by the predecessor plan.;
2529-2530	Change	(cd) “Transition of Care” means the
2531-2532	Change	for physical and oral health and sixty60 days for behavioral health; or
2533-2534	Change	(a) Medically fragile childrenFragile Children;
2535-2536	Change	during the transition of care period.;
2537-2538	Change	(3) has continued access to care. and Non-Emergency Medical Transportation (NEMT);
2539	Deletion	(c) Notwithstanding section) (4)(b), the receiving CCO is responsible
2540-2541	Change	then Medicaid fee-for-service rates.;
2542-2543	Change	authorization of ongoing covered services.;
2544	Insertion	not delay service authorization for the covered service if written documentation of prior
2545-2546	Change	not available in a timely manner.;
2547	Insertion	of care time period, as if the covered services were prior authorized.
2548-2549	Change	historical utilization data within 21seven calendar days of the
2550-2551	Change	calendar days of the member’s effective date withrequest from the receiving CCO.
2552-2553	Change	(a) Data shall be provided in a HIPAA compliant format to...access to care.secure method of file transfer;
2554	Deletion	410-141-3855 Preferred Drug List (Revised 7/30/19)
2555-2556	Change	out from capitation according to sectionssection (
2557-2558	Change	(13), (14), and (1510) of this rule;
2559-2560	Change	under Medicare Part D when the clientmember is fully dual eligible; and
2561-2562	Change	(3) MCEs may use a restrictivepreferred drug list if it allows access to
2563	Deletion	list through prior authorization (PA). The restrictive...alignment must include:
2564-2565	Change	(a) Identical preferred...status; and.
2566	Deletion	(b) Identical criteria...medications on the PDL.

2567	Moved to	(4) As specified in 45 CFR 156.122
2568	Insertion	and 42 CFR 438.10. MCEs shall publish up-to-date,
2569	Deletion	up-to-date, accurate, and complete ~~lists of all covered drugs on their~~ preferred drug lists, including
2570	Insertion	way certain drugs may be obtained. MCEs shall ensure that:
2571-2572	Change	(~~5~~a)
2573	Moved from	) ~~As specified in 45 CFR 156.122~~
2574-2575	Change	~~, the~~The preferred drug list
2576	Deletion	preferred drug list ~~must:~~
2577-2578	Change	~~(a) Exist in a manner~~is easily accessible to members and
2579-2580	Change	(b) ~~Be~~The preferred drug list is accessible on the
2581-2582	Change	accessible on the ~~plan~~MCE
2583-2584	Change	web link or tab without requiring ~~an individual~~a member to access account or policy number;
2585-2586	Change	(d) If ~~the issuer~~an MCE has more than one plan,
2587-2588	Change	has more than one plan, ~~the member shall~~members may be easily able to discern which
2589	Deletion	be easily able to discern which ~~of the~~ preferred drug
2590-2591	Change	preferred drug ~~lists~~list applies to which plan.
2592-2593	Change	(~~6~~5) The preferred drug list shall:
2594-2595	Change	(~~7~~6) MCEs shall cover at least one
2596-2597	Change	contraception within each of the ~~eighteen~~18 methods identified by the FDA.
2598	Deletion	from a PCP or other participating ~~provider.~~
2599	Deletion	~~(8) MCEs shall provide their participating~~ providers
2600-2601	Change	providers ~~and their pharmacy subcontractor with:~~.
2602	Deletion	~~(a) Their drug list and…listed requests;~~
2603	Deletion	~~(b) Updates made to their…but are not limited~~

		~~to:~~
2604	Deletion	~~(A) Addition of a new drug;~~
2605	Deletion	~~(B) Removal of a previously listed drug; and~~
2606	Deletion	~~(C) Generic substitution.~~
2607-2608	Change	(~~9~~7) Prior authorization for prescription
2609-2610	Change	(~~10~~8) MCEs shall authorize the provision
2611-2612	Change	(~~11~~9) MCEs may not authorize payment
2613-2614	Change	~~https://d...48d-4e3e~~https://d...48d-4e3e
2615-2616	Change	(~~12~~10) The Authority shall pay for a
2617-2618	Change	reimburse providers for carved-out drugs~~.~~;
2619-2620	Change	(~~13~~11) MCEs shall submit quarterly
2621-2622	Change	) MCEs shall submit quarterly ~~utilization~~encounter data within 45 days after the end
2623-2624	Change	(~~14~~12) MCEs are encouraged to provide
2625-2626	Change	(~~15~~13) MCEs shall utilize a pharmacy
2627	Deletion	) MCEs shall utilize a pharmacy~~,~~ and therapeutics (P&T) committee
2628-2629	Change	for both committee types are met~~.~~;
2630-2631	Change	shall be held at least quarterly~~.~~;
2632-2633	Change	meet federal reporting obligations~~.~~;
2634	Insertion	educational programs as each is defined and described by 42 CFR 456, subpart K
2635-2636	Change	by 42 CFR 456, subpart K~~.~~ and Section 1902(oo) of...[42 U.S.C. 1396a(oo)].
2637	Deletion	410-141-3860 Integration and Coordination
2638-2639	Change	achieve the objectives of providing ~~MCE~~CCO members integrated person-centered
2640-2641	Change	person-centered care and services, ~~MCEs~~CCOs shall assure that physical, behavioral,
2642	Insertion	community health improvement plan. CCOs shall be required...(20) of this rule.
2643-2644	Change	(2) ~~MCEs~~CCOs shall develop, implement, and participate
2645-2646	Change	(3) ~~MCEs~~CCOs shall coordinate physical health,

2647-2648	Change	enrollee receives from any other ~~MCE~~CCO;
2649-2650	Change	(4) ~~MCEs~~CCOs shall develop evidence-based
2651	Insertion	shall develop evidence-based and, whenever possible, innovative flexible and creative
2652	Insertion	flexible and creative strategies, for use within their delivery system
2653-2654	Change	To the maximum extent feasible, ~~MCEs~~CCOs shall develop and use patient-centered
2655	Insertion	implementing a network of PCPCHs by:
2656	Insertion	(a) Making PCPCHs
2657	Deletion	PCPCHs ~~shall become~~ the focal point of coordinated
2658-2659	Change	(b) ~~MCEs shall develop~~Developing and implementing mechanisms that encourage providers
2660-2661	Change	communicate and coordinate care with ~~the PCPCH~~PCPCHs in a timely manner, using electronic
2662-2663	Change	electronic health information technology ~~where~~when the technology is available;
2664	Insertion	available; and
2665-2666	Change	(c) ~~MCEs shall engage~~Engaging other primary care provider (PCP)
2667	Deletion	~~(d) CCOs shall administer...and the CCO contract.~~
2668-2669	Change	(6) If ~~an MCE~~,
2670	Moved to	in addition to the use of PCPCH
2671	Insertion	, a CCO implements other models of patient-centered
2672	Moved from	patient-centered primary health care ~~in addition to the use of PCPCH~~, the
2673-2674	Change	, the ~~MCE~~CCO shall ensure member access to
2675	Insertion	shall ensure member access to effective coordinated care services that
2676-2677	Change	coordinated care services that ~~provide effective~~include wellness and prevention
2678-2679	Change	wellness and prevention~~, coordination of care~~

		services, active management and support
2680-2681	Change	active management and support of ~~individuals~~members with special health care needs,
2682	Deletion	with special health care needs, ~~a~~ patient and family-centered approach
2683-2684	Change	and behavioral health care needs. ~~The MCE~~To that end the CCO shall
2685	Insertion	shall be required to:
2686-2687	Change	(a) ~~Demonstrate that~~Ensure each member has a primary care
2688-2689	Change	primary care provider of any eligible ~~MCE~~CCO participating provider type. If
2690-2691	Change	from the date of enrollment, the ~~MCE~~CCO shall ensure the member has an
2692	Insertion	designating a practitioner or entity. CCOs shall document in...with this subsection (a);
2693	Insertion	member. The member must be provided with information on how to contact their
2694-2695	Change	(c) ~~MCEs shall develop~~Develop services and supports for primary
2696	Insertion	services and supports for primary and behavioral health care that
2697-2698	Change	care that ~~are geographically...the member's residence~~meet the access to care...in OAR 410-141-3515 and
2699	Insertion	and which are, if available, offered in nontraditional
2700-2701	Change	communities, and underserved populations. ~~MCEs~~CCOs shall
2702	Insertion	shall also ensure that all other services
2703-2704	Change	all other services and supports ~~are provided as close to...s residence as possible.~~meet the access to care...in OAR 410-141-3515; and
2705-2706	Change	(d) ~~MCE~~Allow eligible members who are Indians
2707	Deletion	members who are Indians ~~shall be permitted~~ to select

2708-2709	Change	to select ~~an~~as their primary care provider:
2710	Insertion	(A) An Indian health care provider (IHCP)
2711-2712	Change	Indian health care provider (IHCP) ~~that~~who is
2713	Deletion	is ~~participating as~~ a primary care provider within
2714	Insertion	primary care provider within the CCO's provider network
2715-2716	Change	network ~~of the MCE~~; or
2717	Deletion	or ~~may select an~~
2718	Insertion	(B) An out-of-network IHCP from whom the
2719-2720	Change	out-of-network IHCP from whom the ~~enrollee~~member is otherwise eligible to receive
2721	Insertion	(7) MCEs shall establish and enter into hospital and specialty service agreements
2722-2723	Change	agreements that include the role of ~~patient-centered primary care homes~~PCPCHs and that specify processes for
2724-2725	Change	(8) ~~MCEs~~CCOs shall meet
2726	Insertion	shall meet all of the following requirements relating
2727-2728	Change	(a) ~~MCEs shall demonstrate how~~Require hospitals and specialty services
2729-2730	Change	hospitals and specialty services ~~shall~~to be accountable
2731-2732	Change	be accountable ~~to achieve~~for achieving successful transitions of care
2733-2734	Change	successful transitions of care~~. MCEs shall ensure~~;
2735	Insertion	(b) Ensure members are transitioned out of
2736-2737	Change	settings, and the State Hospital~~.~~;
2738-2739	Change	(~~b~~c) When a member's care is being
2740-2741	Change	care is being transferred from one ~~MCE~~CCO to another or for OHP clients transferring
2742-2743	Change	transferring from fee-for-service to ~~an MCE~~a CCO, the
2744-2745	Change	, the ~~MCE~~CCO shall make every reasonable effort
2746-2747	Change	OHP client into the care of an ~~MCE~~CCO

		participating provider
2748-2749	Change	participating provider~~.~~;.
2750-2751	Change	(~~c~~d)
2752-2753	Change	) ~~The MCE shall implement~~Implement systems to assure and monitor transitions
2754-2755	Change	subcontractors receive information on the ~~process~~processes for members accessing care coordination
2756-2757	Change	members accessing care coordination~~.~~;.
2758-2759	Change	(~~d~~e) For members who are discharged
2760-2761	Change	to post hospital extended care ~~at the time of admission~~by being admitted to
2762	Deletion	to ~~a~~ skilled nursing facility (SNF),
2763-2764	Change	skilled nursing facility (SNF), the ~~MCE~~CCO shall notify the appropriate Department
2765-2766	Change	appropriate discharge planning. The ~~MCE~~CCO shall pay for the full 20-day post-hospital
2767-2768	Change	post-hospital extended care benefit when ~~appropriate~~the full 20 days is...the discharging provider, if the member was enrolled in
2769-2770	Change	the member was enrolled in the ~~MCE~~CCO during the hospitalization preceding
2771-2772	Change	(A) ~~MCEs~~CCOs shall notify the SNF and the member
2773	Insertion	post-hospital extended care (PHEC) that the post-hospital...be paid for by the CCO;
2774	Insertion	discharged to Medicare Skilled Care Unit within a SNF, the
2775-2776	Change	, the ~~MCE~~CCO shall notify the appropriate Department
2777-2778	Change	appropriate Department office when the ~~MCE~~CCO learns of the admission. Goals
2779	Insertion	s care; and
2780-2781	Change	(C) ~~MCEs~~CCOs shall coordinate transitions to
2782-2783	Change	(~~e~~f)
2784-2785	Change	) ~~MCEs~~CCOs shall ensure that the member and

2786-2787	Change	care. Specific requirements for ~~MCE~~CCO care coordinator participation
2788-2789	Change	(9) ~~MCEs~~CCOs shall work across provider networks
2790	Insertion	prevention and self-managed programs as follows:
2791-2792	Change	(a) ~~The MCE shall establish~~Establishing procedures for coordinating member
2793-2794	Change	for access to and coordination of ~~MCE~~CCO services with long-term care services
2795-2796	Change	(b) ~~MCEs shall develop a Memorandum of Understanding~~Developing and entering...of understanding (
2797-2798	Change	(~~MOU~~MOUs) or
2799-2800	Change	) or ~~contract~~contracts with the local type B Area Agency
2801-2802	Change	s APD~~, detailing~~ that details their system coordination agreements
2803	Insertion	receiving Medicaid-funded LTCSS; and
2804-2805	Change	(c) ~~MCEs shall establish agreements~~Developing and entering into MOUs or contracts with the Local Mental Health Authorities
2806-2807	Change	(10) ~~An MCE may~~CCOs shall cover and reimburse inpatient psychiatric
2808-2809	Change	inpatient psychiatric services, ~~not including substance use disorder treatment~~except when those services are provided at an Institution for Mental Diseases
2810-2811	Change	(IMD) as defined in 42 CFR 435.1010~~. (See~~ and OAR 410-141-3500
2812	Deletion	OAR 410-141-3500 ~~for the definition of an IMD~~.
2813	Deletion	.~~)~~ The state may
2814	Insertion	The state may, however, make a monthly capitation payment
2815-2816	Change	inpatient psychiatric services ~~for~~provided at an IMD as an alternative
2817	Deletion	an alternative ~~service or~~ setting

2818-2819	Change	setting~~, incorporating~~ to those covered under the state plan, when all
2820	Insertion	all of the following requirements
2821-2822	Change	the following requirements ~~as defined~~are met in
2823	Insertion	in accordance with 42 CFR 438.6(e):
2824-2825	Change	(a) ~~For members~~The member receiving services is aged 21-64;
2826-2827	Change	(b) ~~As inpatient psychiatric~~The services
2828	Insertion	services are provided for a short-term
2829	Deletion	for a short-term ~~stay~~ of no more than 15 days during the
2830	Insertion	the monthly capitation payment; and
2831	Deletion	(c) The provision of ~~inpatient psychiatric~~ services
2832-2833	Change	services ~~in an~~at the IMD
2834-2835	Change	IMD ~~shall meet~~meets the requirements for
2836	Insertion	the requirements for "in lieu of services
2837	Insertion	in lieu of services" as
2838-2839	Change	as ~~defined~~set forth in 42 CFR 438.6(e)(2)(i) through
2840	Insertion	CFR 438.6(e)(2)(i) through (iii), which requires all of the following:
2841-2842	Change	(A) The ~~alternative service or setting~~IMD is a medically appropriate and
2843-2844	Change	(B) The ~~MCE~~CCO must offer
2845	Insertion	must offer members the option to access the state plan
2846-2847	Change	access the state plan services and ~~may~~shall not require
2848-2849	Change	not require ~~a member~~members to use the IMD as an alternative
2850	Insertion	alternative service or setting; and
2851-2852	Change	authorized and identified in the ~~MCE contract~~CCO contracts and
2853	Deletion	and ~~may be~~ offered to members at the
2854-2855	Change	offered to members at the ~~MCE~~CCO

2856-2857	Change	(11) If ~~the~~a member is living in a Medicaid-funded
2858-2859	Change	other residential facility, the ~~MCE~~CCO shall communicate with the member
2860-2861	Change	(12) ~~An MCE~~CCOs shall
2862-2863	Change	shall ~~demonstrate that~~ensure their participating providers have the
2864-2865	Change	Health and Human Services. The ~~MCE~~CCOs shall also
2866-2867	Change	shall also ~~demonstrate ability to~~ensure that they facilitate information
2868-2869	Change	facilitate information ~~exchange~~exchanges between other providers and facilities
2870	Insertion	electronic health record capabilities). Compliance with the...with OAR 410-141-3525:
2871-2872	Change	(a) ~~MCE~~CCOs shall require that providers and
2873-2874	Change	Education described in 410-141- ~~AAAA-SDOH/HE (4)~~ 3735:
2875	Deletion	(b)~~.~~
2876-2877	Change	~~(b) The MCE~~ CCOs shall communicate
2878-2879	Change	shall communicate ~~its~~their integration and coordination policies
2880-2881	Change	necessary to ensure compliance. ~~MCEs~~CCOs shall document all monitoring and
2882-2883	Change	(13) ~~MCEs~~CCOs shall ensure that members receiving
2884-2885	Change	as soon as reasonably possible. ~~MCEs~~CCOs shall coordinate the care of members
2886-2887	Change	coordinate the care of members ~~that~~who enter the Oregon State Hospital
2888-2889	Change	were members upon entering the ~~state hospital~~Oregon State Hospital and
2890	Insertion	and when they are transitioning
2891-2892	Change	are transitioning ~~from~~out of the Oregon State Hospital.
2893	Deletion	(14) ~~MCEs~~
2894	Moved to	Except as provided in OAR 410-141-3800.

2895	Insertion	CCOs shall coordinate a member
2896	Insertion	s care outside the CCO's service...coordinate member care even when services or placements
2897-2898	Change	services or placements are outside the ~~MCE~~CCO service area
2899	Deletion	service area~~. MCE assignment is based...origin or jurisdiction~~. Temporary placements by the Authority,
2900	Insertion	by the Authority, Department, or providers who are responsible for health
2901-2902	Change	health ~~services~~service placements for services including
2903	Insertion	including residential placements, may be located
2904-2905	Change	may be located ~~out of~~outside the service area; however, the
2906-2907	Change	the service area; however, the ~~MCE~~CCO shall coordinate care while in
2908-2909	Change	discharge planning for return to the ~~county of origin or jurisdiction~~home CCO. For out of
2910	Insertion	. For out of service area placements, an
2911	Deletion	area placements, an ~~out of area~~ exception shall be made for the
2912-2913	Change	be made for the member to retain ~~the MCE~~home CCO enrollment
2914	Deletion	enrollment ~~in the county of origin or jurisdiction,~~ while the member
2915	Deletion	residential placement elsewhere~~. For program placements...program specific rules.~~
2916	Deletion	~~(15)~~
2917	Moved from	~~Except as provided in OAR 410-141-3800,~~
2918	Deletion	~~MCEs shall coordinate...not available in Oregon~~:
2919-2920	Change	(a) ~~MCE enrollment~~CCOs shall
2921-2922	Change	shall ~~be maintained in the...expectation of the MCE~~, prior to
2923	Insertion	to discharge, coordinate care

2924	Insertion	coordinate care in accordance with
2925	Deletion	with ~~the out of area placement and local providers;~~
2926-2927	Change	~~(b) The MCE shall coordinate the~~a member's discharge
2928-2929	Change	discharge ~~planning~~plan when the member returns to
2930-2931	Change	when the member returns to ~~the county of origin.~~their home CCO; or
2932-2933	Change	(~~c~~b) If a member loses Medicaid coverage
2934-2935	Change	(~~16~~15)
2936-2937	Change	) ~~MCEs~~CCOs shall coordinate and authorize
2938-2939	Change	services and providers outside the ~~MCE~~CCO
2940-2941	Change	specialty not otherwise contracted. The ~~MCE~~CCO shall pay
2942	Insertion	shall pay for the services and treatment plan
2943-2944	Change	rules outlined in OAR 410-141-3835 ~~MCE~~CCO Service Authorization.
2945-2946	Change	(~~17~~16)
2947-2948	Change	) ~~MCEs~~CCOs shall coordinate with Community
2949	Deletion	response to members experiencing ~~a~~ behavioral health
2950-2951	Change	behavioral health ~~crisis~~crises and to prevent inappropriate use
2952-2953	Change	(~~18~~17)
2954-2955	Change	) ~~MCEs~~CCOs shall perform care coordination
2956-2957	Change	those terms are defined in OAR ~~309-035-0105~~410-141-3500.
2958-2959	Change	(~~19~~18)
2960-2961	Change	) ~~MCEs~~CCOs shall
2962	Deletion	shall ~~monitor the...efforts. MCEs must~~ implement at least
2963-2964	Change	implement at least ~~1~~one outcome measure tool for care coordination
2965	Deletion	care coordination services at the ~~PCP-managed Care...level and one at the~~ ICC Care Coordination level

2966	Deletion	ICC Care Coordination level). CCOs shall collaborate with the
2967-2968	Change	(2019)
2969-2970	Change	) The MCE must report...to the Authority on itsCCOs shall monitor and document their care coordination activities
2971	Insertion	care coordination activities and the effectiveness of...Authority semi-annually. The
2972-2973	Change	. The MCECCO is subject to appropriate corrective
2974-2975	Change	contents of the report reveal that the MCECCO
2976-2977	Change	requirements are not being met. TheFor each reporting period the report must contain:
2978-2979	Change	(a) An identificationIdentification of care coordination practices
2980	Insertion	coordination practices used with members and the frequency with...practices were used;
2981	Deletion	(b
2982	Insertion	(b) Identification of the...of such members;
2983	Insertion	(c) An overall review of care coordinators
2984-2985	Change	coordinators performing services for the MCECCO, separated by employed and delegated
2986-2987	Change	(cd) Identification of any significant
2988	Insertion	events that occurred to members, including, without limitation:
2989	Insertion	(A) Incarceration;
2990	Deletion	(d
2991	Insertion	(B) Reassessment triggers; and
2992	Insertion	(C) Sentinel events;
2993	Insertion	(e) Data on
2994	Insertion	) Data on the type and frequency of
2995	Insertion	frequency of reassessment triggers
2996	Deletion	triggers for re-assessment...the reporting period;
2997	Deletion	(e) Activity logs of Care Coordination services;
2998	Deletion	coordination with network providers; and

2999-3000	Change	plans to improve common grievances~~.~~;
3001	Deletion	~~(21) The MCE must identify a~~
3002	Insertion	(h) Identification of
3003	Moved to	milestones and accomplishments
3004	Insertion	; and
3005	Insertion	(i) A plan to improve the overall process
3006-3007	Change	coordination access for its Members. ~~This~~The plan shall also include discussion
3008-3009	Change	coordination system within their CCO. ~~This~~The plan is subject to approval by
3010	Deletion	plan is subject to approval by the ~~MCE board and must be updated semiannually with~~
3011	Moved from	~~milestones and accomplishments~~
3012	Insertion	CCOs' governing boards.
3013	Deletion	410-141-3865 Care Coordination Requirements
3014-3015	Change	(1) ~~The CCO~~CCOs will ensure continuous care management
3016	Deletion	care management for all members~~, not only those in ICC...location of the member~~.
3017-3018	Change	(2) ~~The MCE~~CCOs shall conduct a health risk screening
3019	Insertion	conduct a health risk screening, which shall include a...behavior health issues, for each new member
3020	Insertion	for each new member in accordance with OAR 410-141-3870. This screening is distinct from
3021-3022	Change	assessment of special health care needs~~.~~ :
3023-3024	Change	(a) ~~MCEs~~CCOs must use a universal screening
3025-3026	Change	use a universal screening process ~~that assesses~~to evaluate all members for critical risk factors
3027	Deletion	intensive care coordination for ~~high-needs~~ members
3028-3029	Change	members~~.~~ with special health care needs;
3030-3031	Change	screened upon initial enrollment with ~~the~~

		~~MCE~~their CCO. This screening shall be completed
3032	Deletion	This screening shall be completed ~~and documented as quickly as~~
3033	Moved from	~~the member's health condition~~
3034-3035	Change	~~requires, but at least within~~as follows:
3036	Insertion	(A) Within 90 days of the effective date of
3037	Insertion	90 days of the effective date of initial enrollment
3038-3039	Change	enrollment ~~for all new members, or within~~;
3040	Insertion	(B) Within 30 days
3041	Insertion	30 days of the effective date of initial enrollment when the member is
3042-3043	Change	when the member is ~~referred or is receiving~~:
3044	Insertion	(i) Referred; or
3045	Insertion	(ii) Receiving Medicaid-funded long-term care,
3046	Deletion	Medicaid-funded long-term care, services~~,~~ and supports
3047	Insertion	and supports (LTCSS); or
3048	Deletion	or ~~is~~
3049	Insertion	(iii) Is a member of a priority population
3050	Deletion	member of a priority population ~~for ICC,~~ as
3051-3052	Change	as ~~described~~such term is defined in OAR 410-141-3870(2)
3053	Insertion	in OAR 410-141-3870(2); or
3054	Insertion	(C) Sooner than required...or (B) if required by
3055	Moved to	the member's health condition.
3056	Moved from	(c) ~~Members~~
3057	Insertion	CCOs shall
3058	Moved from	shall ~~be reassessed~~
3059	Insertion	rescreen members annually
3060	Deletion	annually~~, upon a change in responsibility,~~ or
3061	Insertion	or sooner if there is a change in health status indicating
3062	Insertion	need for an updated assessment. Members shall be...or ICC services;

3063	Deletion	~~(d) MCEs shall ensure...overutilizes services.~~
3064	Deletion	~~(e) MCEs shall maintain documentation of~~
3065	Insertion	(d) If a member's health...health risk screening;
3066	Insertion	(e) All Screenings and...and person-centered.
3067	Insertion	(3) CCOs shall document all
3068-3069	Change	all ~~completed~~screenings and assessments
3070-3071	Change	assessments~~. If~~ in the
3072-3073	Change	the ~~MCE~~member's case file:
3074	Insertion	(a) If a CCO requires additional information
3075-3076	Change	information from the member to complete ~~an~~a screening or assessment, the
3077-3078	Change	assessment, the ~~MCE~~CCO shall document all attempts to
3079-3080	Change	the member by telephone and mail~~.~~;
3081	Deletion	~~(f) In an effort to...member's record. An MCE~~
3082	Insertion	(b) CCOs shall maintain...with OAR 410-141-3520;
3083	Insertion	(c) CCOs shall share the results of
3084-3085	Change	shall share the results of ~~its assessment,~~member assessments and screenings consistent with ORS 414.679 and
3086	Insertion	consistent with ORS 414.679 and all other applicable
3087	Insertion	applicable state and federal privacy
3088-3089	Change	privacy ~~requirements~~laws with
3090	Insertion	with the following:
3091	Deletion	(C) Members receiving ~~Medicaid-funded~~ LTCSS and, if approved by the member,
3092-3093	Change	(~~3~~4)
3094-3095	Change	) ~~MCEs~~CCOs shall have processes to ensure
3096	Insertion	long-term services and supports (LTSS) and
3097-3098	Change	and ~~identify appropriate~~for identifying those members
3099-3100	Change	members ~~for referrals~~requiring referral to the Department for
3101-3102	Change	to the Department for ~~long-term services and~~

		~~supports~~LTSS.
3103-3104	Change	(~~4~~5)
3105-3106	Change	) ~~MCEs'~~CCOs shall require their care coordinators shall develop,
3107-3108	Change	coordinators shall develop, and ~~MCEs~~CCOs shall require their provider network
3109-3110	Change	member, particularly those with ~~intensive care coordination~~ICC needs, including
3111-3112	Change	needs, including ~~members~~those with serious and persistent mental
3113	Deletion	Plan Amendment and those receiving ~~Medicaid-funded~~ LTCSS.
3114-3115	Change	(~~5~~6) A member
3116	Insertion	s care plan must at a minimum:
3117-3118	Change	information provided by community partners~~.~~;
3119-3120	Change	compiled in cooperation with the member~~.~~;
3121-3122	Change	accordance with OAR 410-141-3835 ~~MCE Service Authorization.~~;
3123	Deletion	(d) ~~Be developed within 30...a specialized program.~~ For members enrolled in ICC or a
3124-3125	Change	For members enrolled in ICC or a ~~specialized~~condition-specific program,
3126	Insertion	program, intensive care
3127	Insertion	care coordination plans
3128	Insertion	plans (ICCP) must be developed within 10 days
3129	Insertion	updated every 90 days, or sooner if health care
3130	Deletion	care ~~plan~~ needs change.
3131-3132	Change	(~~6~~7) Care plans
3133-3134	Change	) Care plans ~~shall~~must reflect the member
3135-3136	Change	caregiver preferences and goals~~.~~;
3137	Insertion	(a) Care plans shall be trauma-informed,
3138	Insertion	appropriate and person-centered;
3139-3140	Change	(~~a~~b) To ensure engagement and satisfaction
3141	Insertion	and satisfaction with care plans, care coordinators shall:

3142	Insertion	(A) Actively engage members
3143	Deletion	members ~~shall participate~~ in the creation of care plans
3144-3145	Change	in the creation of care plans~~.~~;
3146	Deletion	~~(b) Members must~~
3147	Moved from	~~be provided a copy of...or changes to the plan.~~
3148	Insertion	(B) Ensure members...their care plans; and
3149	Insertion	(C) Ensure members...in their care plans.
3150	Deletion	coordinators shall actively engage ~~members and~~ caregivers
3151	Insertion	caregivers in the creation of member care plans and shall ensure that they understand
3152-3153	Change	to fulfill their responsibilities~~.~~;
3154	Deletion	(d) If ~~a member's~~ participation
3155	Insertion	participation in creating a member's care plan would be significantly detrimental
3156-3157	Change	s care or health, ~~a~~the member
3158	Insertion	member, the member's caregiver, or the member's family may be excluded from the development
3159-3160	Change	from the development of a care plan ~~and denied access to~~. The CCO must document...be documented as above;
3161	Insertion	(e) Members shall
3162	Moved to	be provided a copy of...or changes to the plan.
3163	Insertion	However, if providing the member with a copy of
3164-3165	Change	a copy of ~~the~~their care plan
3166-3167	Change	plan~~. The MCE~~ would be significantly...from the member. CCOs must document the reasons for
3168	Insertion	must document the reasons for withholding the
3169-3170	Change	the ~~exclusion~~care plan, including a specific description
3171-3172	Change	member, and describe what attempts ~~have~~

		~~been~~were made to ameliorate the risk(s).
3173	Insertion	update, and the decision to continue withholding the
3174-3175	Change	the ~~exclusion must~~care plan shall be documented as above.
3176-3177	Change	(~~7~~8) A member may decline care coordination
3178-3179	Change	decline care coordination and ICC. ~~The MCE~~CCOs shall explicitly notify members
3180	Insertion	notify members that participation in care coordination or ICC is voluntary, and that treatment
3181-3182	Change	(~~8~~9)
3183-3184	Change	) ~~An MCE's care~~Care coordinators
3185-3186	Change	coordinators ~~must~~shall perform their care coordination
3187	Deletion	(a~~) A care coordinator will:~~
3188	Deletion	(~~A~~) Use trauma informed
3189	Deletion	) Use trauma informed ~~care~~, culturally responsive and linguistically
3190	Insertion	care, motivational interviewing, and other patient-centered tools
3191-3192	Change	(~~B~~b)
3193-3194	Change	) ~~Set~~Work with members to set agreed-upon goals
3195	Deletion	agreed-upon goals ~~for the member~~ with continued CCO network support
3196-3197	Change	(~~C~~c) Promote utilization of preventive,
3198-3199	Change	(~~D~~d) Focus on prevention, and when
3200-3201	Change	(~~E~~e) Provide evidence-based condition
3202-3203	Change	(~~F~~f) Promote medication management,
3204-3205	Change	(~~G~~g) Have contact with
3206	Insertion	) Have contact with, if the member is...program, the active
3207-3208	Change	the active ~~program~~condition-specific care team at least twice
3209-3210	Change	(~~b~~10) Care coordinators shall promote
3211-3212	Change	(~~A~~a)

3213-3214	Change	) ~~Shall continue through episodes~~Episodes of care, regardless of
3215	Insertion	of care, regardless of the member's location
3216	Deletion	location ~~of individual~~;
3217-3218	Change	(~~B~~b) Monitoring of conditions and ongoing
3219-3220	Change	(~~C~~c) Adoption of condition management
3221	Insertion	chronic condition exacerbations; and
3222-3223	Change	(~~D~~d) Engaging members, and their family
3224-3225	Change	(~~9~~11)
3226-3227	Change	) ~~An MCE~~CCOs must facilitate transition planning
3228-3229	Change	410-141-3860, care coordinators ~~must take the following steps to~~shall facilitate transitions and ensure
3230-3231	Change	services continue after discharge~~:~~ by taking the steps set forth below.
3232-3233	Change	(a) ~~The member's care...participate and play~~Taking an active role in discharge planning
3234-3235	Change	role in discharge planning from a ~~specialized~~condition-specific facility
3236	Insertion	facility including, without...services facilities.
3237-3238	Change	care, the care coordinator shall ~~have~~do all of the following:
3239	Insertion	(A) Have contact with the member no less
3240-3241	Change	contact with the member no less than ~~2~~two times per month prior to discharge
3242-3243	Change	per month prior to discharge and ~~2~~two times within the week of discharge
3244-3245	Change	times within the week of discharge~~. Care coordinators must attempt to engage~~;
3246	Insertion	(B) Assist in
3247	Insertion	in the facilitation of a
3248	Deletion	a ~~face-to-face~~ warm handoff to relevant care providers
3249-3250	Change	transition of care and discharge planning~~. The care coordinator shall also engage~~; and
3251	Insertion	(C) Engage with the member, face to face,

3252-3253	Change	the member, face to face, within ~~2~~two days post discharge.
3254	Insertion	discharges from an acute care admission, the care coordinator shall have contact
3255-3256	Change	shall have contact with the member ~~within 1~~on a face-to-face basis...possible, as follows:
3257	Insertion	(A) Within one business day of admission
3258-3259	Change	business day of admission~~, 2~~;
3260	Insertion	(B) Two times
3261-3262	Change	times ~~a~~per week while the member is in acute
3263-3264	Change	while the member is in acute care~~,~~; and
3265	Deletion	and ~~no~~
3266	Insertion	(C) No less than
3267-3268	Change	less than ~~2~~two times
3269-3270	Change	times ~~a~~per week within the week of discharge
3271	Deletion	week within the week of discharge~~, on a face-to-face basis if possible~~.
3272-3273	Change	(d) Prior to discharge~~, CCOs will~~ from any residential,...care coordinators shall conduct a transition meeting to
3274	Insertion	plan. This meeting must be held 30 days prior to the member
3275-3276	Change	s return to the ~~Contractor Service Area ,...days prior to discharge,~~CCO's service area or, if...facility or program or as soon as possible if the
3277-3278	Change	or as soon as possible if the ~~MCE~~CCO is notified of impending discharge
3279-3280	Change	impending discharge or transition with ~~fewer~~less than 30 days
3281-3282	Change	supports for the member will continue~~.~~;
3283-3284	Change	(e) ~~The COO~~CCOs must oversee management of all
3285	Deletion	had a lapse in Medicaid coverage, ~~and~~ work to establish services that
3286-3287	Change	currently are not available in their ~~region~~service areas, and if...of Medicaid coverage.

3288-3289	Change	(~~f~~12)
3290-3291	Change	) ~~The MCE must~~CCOs shall supervise care coordinators to
3292	Insertion	coordinators to ensure they are providing the required and appropriate
3293	Insertion	appropriate behavioral, oral, and physical health care services and supports to members
3294	Deletion	services and supports to members ~~and provide full...care coordinators~~. The individual
3295	Insertion	. The individual(s) tasked with
3296	Deletion	tasked with ~~such~~ responsibility
3297-3298	Change	responsibility ~~must~~for supervising care coordinators shall be a licensed master
3299-3300	Change	s-level mental health professional. ~~This supervisory...the CCO itself must hold~~CCOs shall not...for supervising care coordinators
3301	Deletion	care coordinators ~~responsible for ensuring...coordination of care~~.
3302	Moved to	Statutory/Other Authority: ORS 413.042
3303	Insertion	, 414.615, 414.625, 414.635 & 414.651
3304	Moved to	Statutes/Other Implemented: ORS
3305	Insertion	414.610–414.685
3306	Insertion	410-141-3870
3307-3308	Change	~~410-141-3870~~ Intensive Care Coordination
3309	Insertion	(1)
3310-3311	Change	1) ~~MCEs~~CCOs are responsible for
3312-3313	Change	are responsible for ~~intensive care coordination~~Intensive Care Coordination (ICC) services. The requirements
3314-3315	Change	services. The requirements described ~~herein~~in this rule are in addition to the general
3316	Insertion	care coordination requirements and health risk screenings described in OAR 410-141-3860 and
3317	Insertion	(2) “Prioritized Populations” means
3318	Deletion	Populations” means individuals ~~with SPMI, children~~

3319	Moved from	~~0-5 at risk of maltreatment, children~~
3320	Insertion	who:
3321	Moved from	~~showing early signs of social/~~
3322	Deletion	~~emotional or behavioral...with dependent children,~~
3323	Moved from	~~children with neonatal...in Child Welfare~~
3324	Deletion	~~, IV drug users, individuals with~~
3325	Moved from	~~SUD in need of withdrawal management~~
3326	Deletion	~~, individuals with...prioritized members.~~
3327	Deletion	~~(3~~
3328	Insertion	(a)
3329-3330	Change	) ~~MCEs shall make ICC...populations including;~~Are older adults
3331-3332	Change	older adults~~;~~, individuals who are
3333	Deletion	individuals who are ~~blind, deaf, or~~ hard of hearing
3334	Insertion	hard of hearing, deaf, blind, or have other disabilities;
3335	Deletion	or have other disabilities; ~~members with~~
3336	Insertion	(b) Have complex
3337-3338	Change	complex ~~medical needs,~~or high health care needs, or multiple
3339	Insertion	health care needs, or multiple or chronic conditions
3340-3341	Change	chronic conditions~~; those~~, or SPMI, or are receiving Medicaid-funded long-term
3342	Deletion	receiving Medicaid-funded long-term care~~,~~ services
3343	Deletion	services~~,~~ and supports
3344	Insertion	and supports (LTCSS);
3345	Deletion	; ~~those who exhibit...Syndrome; those~~
3346	Insertion	(c) Are children ages
3347	Moved to	0-5 at risk of maltreatment, children
3348	Moved to	showing early signs of social/
3349	Insertion	emotional or behavioral...or have a SED diagnosis;

3350	Insertion	(d) Are in medication assisted treatment
3351-3352	Change	medication assisted treatment for ~~substance use disorder~~SUD;
3353	Insertion	(e) Are pregnant women
3354	Insertion	pregnant women, parents with dependent...guardians of children, and
3355-3356	Change	and ~~women with~~grandparents of dependent
3357-3358	Change	dependent ~~children~~grandchildren;
3359	Insertion	(f) Are
3360	Moved to	children with neonatal...in Child Welfare
3361	Insertion	:
3362	Insertion	(g) Are IV drug users
3363	Insertion	IV drug users, have
3364	Moved to	SUD in need of withdrawal management;
3365	Deletion	; ~~individuals with~~
3366	Insertion	(h) Have HIV/AIDS
3367-3368	Change	HIV/AIDS~~; individuals with~~ or have tuberculosis;
3369	Insertion	(i) Are veterans and their families; and
3370	Deletion	veterans and their families; and ~~individuals~~
3371	Insertion	(j) Are at risk of first episode psychosis
3372	Insertion	risk of first episode psychosis, and individuals within...(IDD) populations.
3373	Insertion	(3) “Intensive Care...as defined in this rule.
3374	Insertion	(4) “Intensive Care...and wellness outcomes.
3375	Insertion	(5) All members of...their health condition. Children
3376-3377	Change	. Children ~~and youth~~who are members of a prioritized population shall be provided
3378	Deletion	shall be provided ~~ICC and~~ behavioral health services according
3379	Deletion	services according to presenting needs. ~~All other members shall...and assessment.~~
3380	Deletion	~~(4) MCEs shall screen...health care needs.~~
3381	Deletion	~~(a) Screenings may take...for ICC services. The~~

3382	Insertion	(6) CCOs shall also...be conducted when:
3383	Insertion	(a) A health risk...a need for ICC services;
3384	Insertion	(b) A member
3385-3386	Change	member~~,~~ refers themselves;
3387	Insertion	(c) A member
3388-3389	Change	s representative~~, HCBS provider, provider, or other~~ or provider, including a...refers the member; or
3390	Insertion	(d) Upon referral of any medical personnel serving
3391-3392	Change	medical personnel serving ~~the member or the~~as a member
3393	Deletion	s ~~Medicaid~~ LTCSS case manager
3394-3395	Change	LTCSS case manager ~~may refer or self-refer...The MCE shall have an~~.
3396	Insertion	(7) CCOs shall have...needs. CCOs shall have established process for responding
3397-3398	Change	established process for responding to ~~such~~all requests
3399	Deletion	requests ~~and refer members~~ for
3400-3401	Change	for ~~a health risk screening...condition requires~~ICC assessments or...within one business day.
3402	Deletion	~~(b) MCEs shall~~
3403	Insertion	(8) ICC assessments shall...needs of a member.
3404	Insertion	(9) For those members not...and, as applicable, reassess members for ICC eligibility
3405	Deletion	reassess members for ICC eligibility~~,~~ revise care plans
3406-3407	Change	revise care plans ~~if necessary~~, and ensure care...triggering event:
3408	Insertion	(a) For those members...the members' ICC plan, and ensure care coordination
3409-3410	Change	and ensure care coordination ~~after notice of any~~efforts are undertaken in...triggering event;
3411	Insertion	(b) Reassessment triggering events include all

		of the following events
3412	Deletion	of the following events ~~within 7 days, except…contacted within 3 days~~:
3413-3414	Change	primary Z code diagnoses within ~~1~~one month;
3415-3416	Change	caregiver placements within past ~~6~~six months;
3417-3418	Change	(S) Exit from ~~specialized~~condition-specific program.
3419	Deletion	(c) ~~Member rescreening~~
3420	Moved to	Members
3421	Insertion	shall
3422	Moved to	be reassessed for ICC
3423-3424	Change	for ICC~~,~~ services and care
3425-3426	Change	and care ~~plan revision, must~~plans or, if applicable, ICC plans shall be
3427-3428	Change	be ~~performed~~revised annually
3429-3430	Change	annually~~.~~:
3431-3432	Change	(d) ~~Member rescreening~~Reassessment for ICC
3433-3434	Change	for ICC~~,~~ services and care
3435-3436	Change	and care ~~plan revision~~plans, or if applicable, ICC plans, revised if necessary, must be performed
3437-3438	Change	(~~5~~10) Members eligible for ICC shall
3439-3440	Change	eligible for ICC shall be assigned ~~a~~an ICC care coordinator
3441-3442	Change	care coordinator~~.~~:
3443	Insertion	(a) ICC Care coordinator assignments must
3444-3445	Change	assignments must be made within ~~3~~three business days
3446-3447	Change	business days~~.~~ of determining a member…for ICC services;
3448-3449	Change	(b) If a member is in a ~~specialized~~condition-specific program at the time they are determined
3450	Insertion	are determined eligible for ICC services, or enters a
3451-3452	Change	, or enters a ~~specialized~~condition-specific program

3453	Insertion	program while receiving ICC services, then the
3454-3455	Change	, then the ~~MCE~~CCO will appoint
3456-3457	Change	will appoint ~~that~~the care coordinator of the
3458-3459	Change	care coordinator of the ~~specialized~~condition-specific program as the
3460	Insertion	program as the ICC care coordinator for the member
3461-3462	Change	member while the member is in the ~~specialized~~condition-specific program. After
3463-3464	Change	program. After ~~transition~~a member transitions from
3465-3466	Change	from ~~the specialized~~a condition-specific program, the CCO must reassess
3467	Insertion	the CCO must reassess the member for ICC services within
3468-3469	Change	within ~~7~~seven calendar days
3470	Insertion	days of the transition and assign a new
3471	Insertion	and assign a new ICC care coordinator
3472-3473	Change	care coordinator ~~in accordance with the provisions above.~~ within three business...of the ICC reassessment;
3474-3475	Change	(c) ~~The MCE~~CCOs shall notify
3476-3477	Change	shall notify ~~the member~~members of their ICC status by at least
3478-3479	Change	two means of communication within ~~5~~five business days following the
3480-3481	Change	business days following the ~~screening~~completion of the ICC assessment. Notifications shall include details
3482-3483	Change	Notifications shall include details ~~of~~about the ICC program and the name and
3484-3485	Change	name and contact information of ~~the~~their assigned ICC care coordinator.
3486-3487	Change	(~~6~~11)
3488-3489	Change	) ~~MCEs~~CCOs shall implement procedures to share
3490-3491	Change	procedures to share the results of

		~~screening~~ICC assessment including, without limitation, identifications
3492-3493	Change	identifications ~~and treatment plans~~made as a result of the...plan (ICCP) created for ICC services
3494	Insertion	for ICC services. CCOs shall share the results with participating providers serving
3495-3496	Change	participating providers serving the member~~;~~, other parties identified in OAR
3497-3498	Change	parties identified in OAR 410-141-~~DDDD;~~3865 and, for members receiving
3499	Deletion	and, for members receiving ~~Medicaid-funded~~ LTCSS,
3500	Insertion	LTCSS, the results should be...physical disabilities (APD
3501	Insertion	APD) and the Office of Developmental
3502	Insertion	with ORS 414.679 and applicable state and federal privacy
3503-3504	Change	privacy ~~requirements~~laws and meet timely access standards
3505-3506	Change	and meet timely access standards ~~defined~~set forth in in 410-141-3515.
3507	Deletion	(~~6) ICC activities include:~~
3508-3509	Change	~~(a) Early identification of members eligible for~~12) ICC services
3510-3511	Change	ICC services~~;~~ shall include, without limitation:
3512-3513	Change	(~~b~~a) Assistance to ensure timely access
3514-3515	Change	(~~c~~b) Coordination with medical and
3516-3517	Change	(~~d~~c) Assistance to medical providers
3518-3519	Change	(~~e~~d) Aid with coordinating necessary
3520-3521	Change	(~~8~~13)
3522	Insertion	) ICC Care coordinators
3523	Deletion	Care coordinators ~~performing ICC~~ must
3524-3525	Change	must ~~carry out~~provide the following services:
3526	Insertion	the member individually at least once every
3527-3528	Change	every ~~3~~three months and make
3529	Insertion	months and make other kinds of contact

3530	Deletion	contact ~~of any kind~~ (face to face when possible)
3531-3532	Change	(face to face when possible) ~~3~~three times a month or more frequently
3533	Insertion	more frequently if indicated. If an ICC care coordinator is unable to
3534-3535	Change	unable to ~~do so~~comply with the member contact requirements, the
3536-3537	Change	, the ~~MCE~~CCO must document attempts made, barriers,
3538	Insertion	document attempts made, barriers, and remediation efforts
3539-3540	Change	efforts~~/plans~~ taken to overcome
3541	Insertion	to overcome the barriers
3542	Deletion	barriers~~.~~
3543	Deletion	~~(b) Attempt~~ to
3544	Insertion	to the member contact
3545	Insertion	contact requirements:
3546	Insertion	(b) Contact the member no more than
3547-3548	Change	the member no more than ~~3~~three calendar days after receiving notification
3549-3550	Change	reassessment trigger described in ~~paragraph~~section (
3551-3552	Change	(~~3~~9)
3553-3554	Change	)~~(b) above~~ of this rule. If an ICC...to contact the member. ICC care coordinators must continue
3555	Insertion	coordinators must continue brief contacts with members who have...a reassessment trigger as long as deemed necessary by the
3556-3557	Change	deemed necessary by the care team~~.~~ before they revert back...of this section (13);
3558	Insertion	s Primary Care Provider (PCP
3559	Insertion	PCP) within
3560-3561	Change	within ~~1~~one month of ICC assignment, no less
3562	Insertion	thereafter, or more often if required by the member's circumstances, to ensure integration of care

3563-3564	Change	, to ensure integration of care.;
3565-3566	Change	interdisciplinary team meetings monthly, or soonermore frequently, based on need. Interdisciplinary
3567	Insertion	with OAR 410-141-3865(7)(d). The ICC care coordinator is responsible
3568	Deletion	(A)
3569	Insertion	(A) Describe the clinical interventions
3570	Deletion	(B)
3571	Insertion	(B) Create a space for the
3572-3573	Change	Create a space for the Membermember to provide feedback on their care,
3574-3575	Change	self-reported progress towards their careICC plan goals and their strengths
3576-3577	Change	between current and prior meeting.;
3578-3579	Change	s individual careICC plan.
3580	Deletion	transition between levels, settings and/or episodes of care.
3581-3582	Change	(912) If a member is enrolled in other
3583	Insertion	member is enrolled in other programs,, including condition-specific programs, where there is a care manager,
3584-3585	Change	the program-specific care manager supportsshall be responsible for supporting specific needs based on their specialty
3586-3587	Change	(1013)
3588-3589	Change	) MCEsCCOs shall implement processes for
3590-3591	Change	shall implement processes for documentationdocumenting all of
3592	Insertion	of the ICC services
3593	Insertion	ICC services provided and
3594-3595	Change	and the development of a...health care needsattempted to be provided...requiring ICC services.
3596-3597	Change	. MCEsCCOs shall produce
3598-3599	Change	shall produce a treatment or service...regular care monitoringICC plans for each member requiring ICC services. Each

3600-3601	Change	. Each ~~treatment~~ICC plan shall:
3602	Insertion	consultations with any specialist(s) caring for the member and DHS long-term
3603-3604	Change	(c) Be approved by the ~~MCE~~CCO in a timely manner if
3605-3606	Change	in a timely manner if ~~MCE~~CCO approval is required;
3607-3608	Change	rules outlined in OAR 410-141-3835 ~~MCE~~CCO Service Authorization; and
3609-3610	Change	(~~11~~14)
3611-3612	Change	) ~~MCEs~~CCOs shall periodically inform all participating
3613-3614	Change	support services available for members ~~and~~. CCOs shall also periodically provide training for patient-centered
3615-3616	Change	care homes and other primary care ~~providers'~~provider staff.
3617-3618	Change	(~~12~~15)
3619-3620	Change	) ~~MCE~~CCO staff
3621-3622	Change	staff ~~performing~~providing or managing ICC care coordination
3623	Deletion	care coordination ~~shall meet the following requirements:~~
3624-3625	Change	~~(a) ICC care coordinators~~services shall be
3626	Insertion	shall be required to:
3627	Insertion	(a) Be available for training, regional
3628-3629	Change	(or their representatives) in the ~~MCE~~CCO
3630-3631	Change	being of a prioritized population~~, aged, blind, or...all their service areas.~~;
3632	Insertion	(b) If a Member is unable to receive
3633-3634	Change	Member is unable to receive services ~~outside of~~during normal business hours, the
3635-3636	Change	normal business hours, the ~~MCE~~CCO shall provide alternative availability
3637	Insertion	alternative availability options for the member
3638-3639	Change	member~~.~~;
3640-3641	Change	(~~b~~c)

3642-3643	Change	) ~~Staff who coordinate or...ICC services shall be~~Be trained for, and exhibit skills
3644	Insertion	in, person-centered care planning and trauma informed care; and communication with and sensitivity
3645-3646	Change	communication with and sensitivity to the ~~unique~~special health care needs of
3647-3648	Change	health care needs of ~~people who are aged,...complex medical needs~~priority populations.
3649-3650	Change	. ~~MCEs~~CCOs shall have a written position description
3651-3652	Change	written position description for ~~the~~its staff
3653	Deletion	staff ~~member(s)~~ responsible for managing ICC services
3654-3655	Change	for staff who provide ICC services~~.~~:
3656-3657	Change	(~~e~~d)
3658-3659	Change	) ~~MCEs~~CCOs shall have written policies that
3660-3661	Change	dedicated to ICC is determined. ~~Policies may not permit...the MCE must follow the~~The ICC policies must...without limitation, care coordination staffing standards
3662-3663	Change	coordination staffing standards ~~for~~such that
3664-3665	Change	that ~~specialized group, if a lower ratio is called for~~the complexity, scope,...ICC services can be met.
3666-3667	Change	(~~13~~16) Consistent with
3668-3669	Change	) Consistent with ~~OAR 410-141-3870~~the requirements under this rule,
3670-3671	Change	, ~~MCEs~~CCOs shall make Integration and Care
3672-3673	Change	outside of normal business hours, the ~~MCE~~CCO shall provide alternative availability
3674-3675	Change	(~~14~~17)
3676-3677	Change	) ~~MCEs~~CCOs shall have a process to provide
3678-3679	Change	have a process to provide members ~~in ICC who have~~with special health care needs
3680	Insertion	special health care needs who are receiving ICC services with direct access to a specialist,

3681	Deletion	410-141-3875 MCE Grievances & Appeals:
3682	Deletion	Definitions and General Requirements ~~(Revised 8/2/19)~~
3683-3684	Change	an adverse benefit determination~~.~~ ;
3685	Deletion	“Adverse Benefit Determination” means~~,~~ any of the following, consistent
3686-3687	Change	OAR 410-141-3900 and 410-120-1860~~.~~ ;
3688-3689	Change	pending, pursuant to OAR 410-141-3910~~.~~ ;
3690-3691	Change	dissatisfaction to the MCE or to ~~a participating provider~~the Authority about any matter other than an
3692-3693	Change	an adverse benefit determination~~, as defined in OAR 410-120-0000~~. Grievances may include,...action is requested.
3694	Insertion	. A Grievance also includes a member
3695-3696	Change	to make an authorization decision~~.~~ ;
3697-3698	Change	who falls within this definition~~.~~ ;
3699	Insertion	requirements found at 42 CFR 438.44 .
3700-3701	Change	in person as well as in writing~~:~~ ;
3702-3703	Change	resolution timeframe for appeals~~.~~ ; and
3704	Deletion	410-141-3880 Grievances & Appeals:
3705	Deletion	Appeals: Grievance Process Requirements ~~(Revised 8/2/19)~~
3706-3707	Change	(b) ~~Notify~~Promptly, but in no event...of the grievance, notify the member in their preferred language
3708-3709	Change	(a) ~~Shall~~May provide its decision related to
3710	Deletion	decision related to oral grievances ~~either~~ orally
3711-3712	Change	orally ~~or~~but shall also, in call...to oral grievances in writing
3713	Insertion	in writing. Both oral and written responses shall be made in the member
3714	Deletion	explain the reason for the decision; ~~and~~
3715	Deletion	s preferred language~~.~~ ;
3716	Insertion	; and
3717-3718	Change	(d) ~~Notifies~~Shall notify members who are dissatisfied with

3719	Deletion	~~(Revised 8/2/19)~~
3720-3721	Change	shall mail the notice at least ~~ten~~10 days before the date the adverse
3722-3723	Change	(B) The MCE receives ~~a clear written statement signed~~notice that the services requested by the member
3724-3725	Change	by the member ~~stating he~~are no longer
3726-3727	Change	no longer ~~wishes services or gives~~desired or the MCE is provided with information that requires termination
3728-3729	Change	requires termination or reduction ~~of~~in services
3730-3731	Change	services ~~and indicates that he...that information;~~:
3732	Insertion	(i) All notices sent by a...signed by the member;
3733	Insertion	(ii) All notices sent by...the member requested.
3734	Deletion	410-141-3890 Grievances & Appeals:
3735	Deletion	Grievances & Appeals: Appeal Process ~~(Revised 8/2/19)~~
3736	Deletion	~~(a)~~
3737	Insertion	(a) The MCE shall ensure the member
3738-3739	Change	appeal requests expedited resolution~~.~~:
3740	Insertion	(b)
3741	Deletion	~~(b)~~ The MCE is considered to have satisfied
3742-3743	Change	day the MCE receives the appeal~~.~~:
3744-3745	Change	initiate a contested case hearing~~.~~:
3746	Deletion	~~(c)~~
3747	Insertion	(b) The member shall file the appeal
3748	Deletion	410-141-3895 Grievances & Appeals:
3749	Deletion	Grievances & Appeals: Expedited Appeal ~~(Revised 8/2/19)~~
3750	Deletion	
3751-3752	Change	requesting a contested case hearing~~.~~:
3753-3754	Change	Contested Case Hearing Procedures~~.~~:
3755	Insertion	behalf of a member, as permitted in OAR 410-141-3890, the provider may
3756-3757	Change	with the procedures in this rule~~.~~:

3758	Deletion	(c) ~~A provider that filed an...of appeal resolution.~~ Appeals brought on the provider
3759	Insertion	s behalf but are governed by OAR 410-120-1560.
3760-3761	Change	exception under section (3), below~~.~~ ;
3762-3763	Change	hearing requests in OAR 410-141-3905~~.~~ ;
3764-3765	Change	s request~~.~~ ;
3766	Deletion	of the hearing request notice of ~~action/~~adverse benefit determination, and
3767-3768	Change	(~~4~~5) The parties to a contested case
3769-3770	Change	(~~5~~6) The Authority shall refer the
3771	Deletion	request along with the notice of ~~action/~~adverse benefit determination or
3772-3773	Change	(~~6~~7) The Authority shall issue a final
3774-3775	Change	(~~7~~8) For reversed appeal and hearing
3776	Deletion	410-141-3905 Grievances & Appeals:
3777	Deletion	410-141-3910 Grievances & Appeals:
3778	Deletion	Appeals: Continuation of Benefits ~~(Revised 8/2/19)~~
3779-3780	Change	contested case hearing is pending~~.~~ :
3781-3782	Change	contested case hearing request ~~for~~form and check the box requesting continuing benefits
3783-3784	Change	continuing benefits ~~before the sooner of~~by:
3785	Deletion	following the date of the notice of ~~action/~~adverse benefit determination or
3786-3787	Change	proposed in the notice, if applicable~~, whichever is later~~.
3788-3789	Change	continuing benefits, no later than ~~ten~~10 days following the date of the
3790	Deletion	410-141-3915 Grievances & Appeals:
3791-3792	Change	all appeals and grievances for ~~ten~~10 years, which must include information
3793-3794	Change	(4) ~~MCES~~MCE's shall submit for the Authority
3795	Deletion	410-141-3920 Transportation: NEMT
3796	Deletion	(NEMT) services for its members. ~~In addition, the...not enrolled in a CCO.~~ For purposes of OAR 410-141-3920

3797	Deletion	purposes of OAR 410-141-3920 to~~,~~ 410-141-3965, references to a “member”
3798-3799	Change	(3) Neither a CCO nor any ~~contracted~~of its Subcontracted transportation
3800-3801	Change	transportation ~~provider~~providers may bill a member for transport
3802-3803	Change	written policies and procedures ~~under which the...in section (1) may~~regarding its NEMT...in the CCO’s other
3804	Moved to	general information materials
3805	Insertion	. The CCO’s written...NEMT services shall:
3806	Deletion	~~(a) Schedule~~
3807	Insertion	(a) Allow members or...to schedule:
3808	Insertion	(A) NEMT services up to 90 days in advance;
3809	Insertion	(B) Multiple NEMT services at
3810-3811	Change	NEMT services at ~~least 24 hours~~one time for recurring appointments up to 90 days in advance; and
3812-3813	Change	(~~b~~C)
3814-3815	Change	) ~~Schedule same~~Same-day NEMT services.
3816	Insertion	(b) Not permit drivers to...for business; and
3817	Insertion	(c) Not permit drivers to...closes for business; and
3818	Insertion	(d) Describe passenger...or reconsideration.
3819-3820	Change	(a) Prior to mailing a notice of ~~action~~adverse benefit determination to a member, the CCO must provide
3821	Insertion	(b) The CCO shall mail.
3822	Moved to	within 72 hours of denial
3823	Insertion	. a notice of
3824-3825	Change	a notice of ~~action~~adverse benefit determination to
3826-3827	Change	to ~~a~~:
3828	Insertion	(A) A member denied a ride
3829	Moved from	member denied a ride ~~within 72 hours of denial~~
3830	Insertion	; and

3831	Insertion	(B) The provider or other...for an appointment.
3832	Deletion	410-141-3925 Transportation: Vehicle
3833-3834	Change	(c) ~~The transportation provider shall comply~~Compliance with
3835-3836	Change	with ~~appropriate~~all applicable local, state, and federal transportation
3837-3838	Change	state, and federal transportation ~~safety standards~~laws regarding
3839	Insertion	regarding vehicle and passenger safety
3840	Insertion	passenger safety standards and comfort.
3841-3842	Change	and comfort. ~~The vehicle~~All vehicles shall include,
3843-3844	Change	shall include, ~~but is not limited to~~without limitation, the following safety equipment:
3845	Insertion	(H) All equipment necessary to securely transport members using wheelchairs
3846-3847	Change	using wheelchairs or stretchers~~, if~~ in accordance with the
3848-3849	Change	the ~~member is using a wheelchair or stretcher~~Americans with...Revised Statute 659A.103.
3850	Insertion	(b) The driver shall not...the Inspector General; and
3851-3852	Change	(~~b~~c) The driver must pass a criminal
3853-3854	Change	be documented and maintained for ~~three~~10 calendar years, even if the CCO
3855-3856	Change	Driving course or equivalent within ~~six~~three months of the date of hire and
3857	Insertion	(c) Completing and maintaining certification for Red Cross-approved First Aid, Cardiopulmonary
3858-3859	Change	procedures courses or equivalent ~~within six months of the...the certification~~prior to driving any members;
3860-3861	Change	course or equivalent course within ~~six~~three months of the date of hire and
3862	Deletion	least every three years thereafter; ~~and~~
3863	Insertion	should they arise during the ride; and

3864	Insertion	(f) Understanding of and...and transportation laws.
3865	Insertion	(6) Emergency Medical...driver provided the CCO:
3866	Insertion	(a) Verifies the...the license annually;
3867	Insertion	(b) Verifies the EMT is...the Inspector General;
3868	Insertion	(c) Conducts its own...(4)(c) of this rule; and
3869	Insertion	(d) Completes the...(b) and (d) through (f).
3870	Insertion	(7) For authorized out-of-state NEMT
3871	Insertion	s service area under any and all of the following circumstances:
3872	Deletion	(a) The member is receiving ~~an OHP~~ covered
3873-3874	Change	covered ~~health care service~~services that
3875-3876	Change	that ~~is~~are not available
3877	Insertion	not available, in accordance with OAR 410-141-3515, in the
3878	Insertion	in the CCO's service area
3879	Deletion	service area ~~but is available in another area of the state~~;
3880	Deletion	(b) The member is receiving ~~an OHP~~ covered
3881-3882	Change	covered ~~service where~~services outside of Oregon, but the
3883	Deletion	the ~~service~~ location is
3884	Moved to	location is contiguous to the CCO's service area
3885	Insertion	and no more than 75 miles from the Oregon
3886	Deletion	75 miles from the Oregon border ~~and is~~
3887	Moved from	~~contiguous to the CCO's service area~~;
3888	Deletion	~~(c) The CCO determines...for the member; or,~~
3889	Insertion	(c) The member is...facility is located; and
3890	Deletion	(d) The member is receiving ~~an OHP~~ covered
3891-3892	Change	covered ~~service~~services outside
3893	Insertion	outside the State of Oregon
3894-3895	Change	of Oregon ~~that~~because the required covered service is not available
3896-3897	Change	is not available ~~in~~within Oregon.

3898	Deletion	410-141-3935 Transportation: Attendants
3899	Deletion	Child and Special Needs Transports ~~(Revised 7/30/19)~~
3900-3901	Change	rule applies to NEMT for children ~~under 15~~12 years of age
3902	Insertion	years of age and under who are eligible for NEMT services
3903-3904	Change	services. The rule also applies to ~~children and young adults~~members with special physical or developmental
3905-3906	Change	members while traveling to and from ~~medical appointments~~covered services and...with OAR 410-141-3930(2) except when:
3907-3908	Change	transport pursuant to OAR 410-141-~~3490~~3940 (Secured Transports); or
3909	Deletion	attendant may also be any adult ~~the parent or guardian...attendant is at least~~ 18 years
3910-3911	Change	18 years ~~of age, and~~or older authorized by the
3912	Insertion	the member's parent or guardian
3913	Deletion	parent or guardian ~~authorizes it~~.
3914-3915	Change	(6) CCOs ~~may~~shall have the right to require the member
3916-3917	Change	(7) ~~The~~Neither the CCO
3918-3919	Change	CCO ~~may not~~nor its subcontractor shall bill additional charges for a member
3920	Deletion	destination and the return trip. ~~The attendant must also...their appointment.~~
3921	Deletion	(5) CCOs shall verify that ~~the Authority has licensed~~ providers of ground or air ambulance
3922	Insertion	ground or air ambulance services have been licensed by the Authority to operate ground or air ambulances.
3923	Deletion	OHP members, the CCO must ensure ~~that~~
3924	Moved to	the ambulance service provider
3925	Insertion	has been licensed by both the Authority and the contiguous
3926	Deletion	Authority and the contiguous state ~~have licensed~~

3927	Moved from	~~the ambulance service provider~~
3928	Insertion	in which it is operating.
3929	Deletion	410-141-
3930-3931	Change	410-141-~~3950~~3955 Transportation:
3932	Insertion	Transportation: Member Service Modifications
3933-3934	Change	Modifications ~~for Individuals with Disabilities~~and Rights
3935-3936	Change	to the health or safety of others~~. A direct threat is one that~~ and which:
3937-3938	Change	policies, practices, or processes~~.~~; and
3939-3940	Change	best available objective evidence ~~that~~which shows:
3941	Moved to	(2) CCOs shall draft...in NEMT vehicles
3942	Insertion	which shall include,...on their websites.
3943	Moved to	(3) CCOs and their...to 943-005-0070.
3944-3945	Change	(~~2~~4)
3946-3947	Change	) ~~CCO's~~CCOs may not apply criteria, standards,
3948	Insertion	standards, or practices that screen out, or tend to screen out
3949	Insertion	or tend to screen out, individuals in a protected class,
3950	Moved from	~~(3) CCOs and their...to 943-005-0070.~~
3951	Moved from	~~Statutory/Other Authority: ORS 413.042~~
3952	Deletion	~~& 414.625~~
3953	Moved from	~~Statutes/Other Implemented: ORS~~
3954	Deletion	~~414.625~~
3955-3956	Deletion	~~410-141-3955...Service Modifications~~
3957	Deletion	~~(1) CCOs shall draft...this information in all~~
3958	Moved from	~~general information materials~~
3959	Deletion	~~such as handbooks.~~
3960	Moved from	~~(2) CCOs shall draft...in NEMT vehicles~~
3961	Deletion	~~and provide the...receiving NEMT services.~~
3962	Deletion	~~(3~~
3963	Insertion	(5) A CCO may modify
3964	Deletion	) A CCO may modify ~~or a member may~~

		~~request modification of~~ NEMT services when the member:
3965-3966	Change	driver or others in the vehicle~~.~~;
3967-3968	Change	(b) ~~Has a health condition that presents~~Presents a direct threat to the driver
3969-3970	Change	a direct threat to the driver~~,~~ or others in the vehicle
3971-3972	Change	others in the vehicle~~, or the member as described in OAR 410-141-3950.~~;
3973-3974	Change	others in the vehicle at risk of harm~~.~~;
3975-3976	Change	without modifying NEMT services~~.~~;
3977-3978	Change	not show up for scheduled rides~~.~~; or
3979	Deletion	~~(4~~
3980	Insertion	(6) A member may request...when the NEMT driver:
3981-3982	Insertion	(a) Threatens to harm the...others in the vehicle;
3983-3984	Insertion	(b) Drives or engages in...in the vehicle at
3985	Insertion	risk of harm; or
3986-3987	Insertion	(c) Presents a direct threat...others in the vehicle.
3988	Insertion	(7) Reasonable modifications include,
3989	Insertion	and receive mileage reimbursement; and
3990-3991	Change	(~~5~~8)
3992	Insertion	) Members shall be advised...any requesting provider. Before modifying services, the
3993	Insertion	s needs; and
3994-3995	Change	Address health and safety concerns~~:~~.
3996-3997	Change	(~~6~~9) The communications discussed in
3998-3999	Change	communications discussed in section (~~5~~8)
4000	Insertion	) of this rule may include:
4001	Insertion	s care team, including any care coordinator, at the request
4002	Insertion	at the request or upon approval of the member or the CCO;
4003-4004	Change	(b) Any ~~another~~other individual of the member
4005-4006	Change	(~~7~~10) Responses to requests for modification

4007-4008	Change	(~~8~~11) A CCO may not modify NEMT services
4009-4010	Change	modify NEMT services under this rule ~~due solely to a request for~~unless the modification...a disability requiring modification or auxiliary aid
4011	Deletion	modification or auxiliary aid ~~based on disability or...protected class status~~.
4012-4013	Change	(~~9~~12) A CCO may not modify NEMT services
4014-4015	Change	(~~10~~13) A CCO shall make all reasonable
4016	Deletion	410-141-3960 Transportation: Member
4017-4018	Change	members for meals when a member ~~travel~~travels:
4019-4020	Change	additional circumstances at the ~~CCOs~~CCO's discretion.
4021	Deletion	410-141-3965
4022	Deletion	410-141-3965 ~~Transportation:~~ Reports and Documentation
4023	Deletion	Reports and Documentation ~~(Revised 8/2/19)~~
4024-4025	Change	documentation on NEMT service denials for ~~three~~10 calendar years, even if the CCO,
4026-4027	Change	provider before the end of the ~~three~~10 years. The Authority may request
4028-4029	Change	information at any time during the ~~three~~10-year retention period.
4030	Deletion	(3~~) For NEMT services...shall include:~~
4031	Deletion	~~(a) The name of the...member, if applicable;~~
4032	Deletion	~~(b) The member's OHP...identification number;~~
4033	Deletion	~~(c) The date and time of...for transportation;~~
4034	Deletion	~~(d) The name of the employee who denied a ride;~~
4035	Deletion	~~(e) The name of the...denying the ride;~~
4036	Deletion	~~(f) The reason for the...supporting the denial;~~
4037	Deletion	~~(g) The date on the...mailed to the member;~~
4038	Deletion	~~(h) Documentation on the...or disposition; and~~
4039	Deletion	~~(i) Notations of oral and...with the member.~~
4040	Deletion	(~~4~~) The Authority may request and

Statistics:	
	Count
Insertions	2064
Deletions	1814
Moved from	81
Moved to	81
Style change	0
Format changed	0
Total changes	4040