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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 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.

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

(20) “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) “Dental Care Organization (DCO)” means an MCE that provides and coordinates dental services as capitated services under OHP.

(22) “The Department” means the Department of Human Services.

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

(24) “Disenrollment” means the act of removing a member from enrollment with an MCE or the Oregon Health Plan.

(25) “Enrollment” means the assignment of a member to an MCE for management and receipt of health services.

(26) “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) “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 on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.

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

(32) "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) "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) "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) "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) "Legal Holiday" means the days described in ORS 187.010 and 187.020.

(37) "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) "Managed Care Entity (MCE)" means, as stated in 42 CFR 457.10, an entity that enters into a contract 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) "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) "Member" means an OHP client enrolled with an MCE.

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

(42) "Mental Health Organization (MHO)" means an MCE that provides capitated behavioral services for clients.

(43) "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) “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) “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) “Oregon Health Plan (OHP)” means Oregon’s Medicaid program together with related state-funded health programs.

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

(50) “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) “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 initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care.

(52) (57) “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) “Service Area” means the geographic area within which the MCE agreed under contract with the Authority to provide health services.

(54) “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.

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 CMS;

(c) Oregon Revised Statutes;

(d) 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 rules based on the category of health service;

(D) OAR chapter 943 division 120 ("Provider Rules");

(e) 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.

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

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

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

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

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

(C) The subcontractor agrees to perform any activities necessary to support the MCE and the state'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 shall select providers using universal application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards.

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO 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 shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application.

(b) CCOs shall screen their 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 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 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 staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(d) The CCO 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 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").

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

(A) Have been terminated from OHP;

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

(g) CCOs 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 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 may not discriminate with respect to participation in the CCO 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 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 contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or

(b) Preclude the CCO 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 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) and (5) 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 to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the CCO'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) through (6) of this rule shall be awarded the costs of the appeal.

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

410-141-3515 Accessibility

(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number and geographic distribution to ensure adequate service capacity to provide available and timely access to medically appropriate covered services for members.

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

(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 and published by the Authority.

(5) MCEs 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 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, in the most appropriate and independent setting, including in their own home or independent supported living.

(7) MCEs 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 LEP and people with disabilities in their service area in compliance with state and federal rules including but not limited to Section 1557 of the Affordable Care Act and the Americans with Disabilities Act.

(9) MCEs 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 behavioral health issues, 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) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services.

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

(11) MCEs 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) Physical health

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

(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) Oral care

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

(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 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 exceed72 hours for assessment and entry.

(vi) Children with serious emotional disturbance: 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

(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 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 certified or 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, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care.

(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 ensuring compliance with these requirements and shall monitor for compliance.

(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, 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 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 health access, and an annual analysis of the MCE's contracted behavioral health workforce.

(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. If the member requests to reschedule, they shall not be penalized for failing to keep 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) Timely rescheduling of missed appointments, as deemed medically appropriate;

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

(iv) Recall or notification efforts; and

(v) Outreach services.

(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.

(17) MCEs 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 care organizations necessary to provide adequate access to oral services in the area where members reside.

(18) MCEs 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 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) If ten 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) Increasing team capacity to a size that is still consistent with fidelity standards; or

(ii) Adding additional Assertive Community Treatment teams; or

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

Statutory/Other Authority: ORS 413.032, 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 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 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 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 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 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 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 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.

(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 an ongoing comprehensive quality assessment and performance improvement program, QAPI 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'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 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 improvement 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 collects timely data including health disparities and other data required by rule or contract 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 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 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 and submit to the Authority an annual written evaluation of the QAPI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the QAPI 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 ongoing improvement activities to address gaps, which will ensure quality of care for MCE's members; and overall effectiveness of the QI program. MCEs shall submit the 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.

(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;

(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.

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;

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

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

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

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

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

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

(a) Deductible or coinsurance amounts;

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

(c) Health services rendered after the termination of the contract between the CCO and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract. Before providing a non-covered service, the provider must complete 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 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) 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 with applicable rules, including those defined in OAR chapter 415, divisions 12, 20, and 50; OAR chapter 309, divisions 18, 19, and 22; 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.

(c) Any facility that meets the definition of a residential treatment facility for substance-dependent persons under ORS 430.010 and 443.400, or of a detoxification center as defined in ORS 430.306, shall be licensed by the Authority as described in OAR 415-012-0000 for the scope of service provided.
(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.

Statutory/Other Authority: ORS 192.527, 192.528, 413.042 & 414.065
Statutes/Other Implemented: ORS 192.527, 192.528, 413.042, 414010, 414.065 & 414.727

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

(1) If a CCO has a dispute with the Authority as a result of a decision that is perceived as adversely affecting a CCO, the CCO 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 to adversely affect the CCO 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.

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

(2) Within thirty calendar days of the conclusion of the administrative review, or such other time as may be agreed to by the CCO and the Authority, the Authority shall send written results of the administrative review to the initiating CCO and any other affected CCO. 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 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 business days after receipt of the final administrative review decision, the CCO may contact the Director of the Authority indicating the CCO's intent to pursue mediation. In that request, the CCO may request to stay the administrative review decision, which the Authority will grant if the CCO alleges sufficient facts and provides good cause for the stay as provided in OAR 137-004-0090.The Authority shall respond within ten business days of the date of the stay request

(5) After both the CCO 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 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, the Authority shall notify all CCOs potentially impacted by the dispute and provide an opportunity for the impacted CCOs to participate in the dispute resolution process. CCOs that opt into the process have, from that time forward, the same rights and responsibilities as the CCO that initiated the dispute.

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

(8) Within ten business days of a selection of a mediator or upon a different schedule, as agreed to by the parties and the mediator, the CCO 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 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 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 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 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 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 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 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) 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 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 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.

(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) 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) 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) 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) 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) (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 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 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 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;

(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 follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

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

(a) MCEs must 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 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 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 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 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 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 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 as the preferred written language by either:

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

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

(e) 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.

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

(a) MCEs' informational materials shall state that Indians 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.

(b) MCEs shall clearly explain to potential members that Indians 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 Indians 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 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).

(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 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) 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 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) 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 of ICC services and how eligible members may 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, 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) 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) 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) 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) 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) 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 410-141-3615in its notice of proposed action. In all cases that the Authority has determined that a 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) 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) The MCE did not make a timely request for a hearing.

(b) Any part of the deficiency or penalty was upheld after a hearing.

(c) 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) 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) 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 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 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) 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) 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) 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) 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) 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 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) 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) 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) 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) 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) The applicant shall describe its planned policies for informing members about access to all types of THWs identified in OAR 410-180-0305

(18) 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) 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) CCOs shall participate in the learning collaborative described in ORS 413.259. Applicants shall confirm their intent to participate.

(21) 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) 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) 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) 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) 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) 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) 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) 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) 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) 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 every30 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) 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) 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) 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.

(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 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 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 calendar days of receipt of the LOIA.

(5) Within thirty 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 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 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) 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) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-HE partners, as defined in OAR 410-141-3735;

(d) Local public health authorities;

(e) Local mental health authorities and community mental health programs;

(f) Hospitals;

(g) Physical, behavioral, and oral health care providers;

(h) Indian Health Care Providers;

(i) Traditional Health Workers;

(j) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(k) Culturally specific organizations, including Regional Health Equity Coalitions;

(l) Representatives from populations who are experiencing health and health care disparities;

(3) The CHA must include or identify and analyze, 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) Access to primary prevention resources;

(B) Disproportionate, unmet, health-related needs;

(C) Description of assets within the Community that can be built on to improve the Community's health;

(D) Systems of seamless continuum of care; and

(E) Systems or programs of collaborative governance of community benefit.

(g) Identify programs that promote the health and 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;

(h) Identify areas for improvement; and

(i) Document 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 or other factors. This data will be used to identify and prioritize 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) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-HE partners, as defined in OAR 410-141-3735;

(d) Local public health authority;

(e) Hospitals

(f) Local mental health authorities and community mental health programs;

(g) Physical, behavioral, and oral health care providers;

(h) Indian Health Care Providers;

(i) Traditional Health Workers;

(m) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions;

(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) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:

(A) Closing the gap on disproportionate, unmet, health-related needs;

(B) Creating access to primary prevention;

(C) Building a system of seamless continuum of care;

(D) Building on current Community resources and improving Community capacity to improve health or address SDOH/HE, or both; and

(E) Engaging the Community in the implementation of the CHP.

(b) The CHP strategies should be based on research and may include, without limitation:

(A) Developing a Health Policy that supports the CHP goals and objectives;

(B) Implementing community health or SDOH/HE interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

(C) Developing public and private resources and capacities;

(D) Designing and building a system of Integrated service delivery;

(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 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:

(A) Include 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 adequacy of existing school-based resources including school-based health centers (SBHC) to meet the specific pediatric and adolescent health care needs in the community; 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;

(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) 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 and establishes requirements for the social determinants of health and equity (SDOH-E) spending programs, role of the Community Advisory Councils in supporting SDOH-E, and for developing health equity infrastructure within a Coordinated Care Organization (CCO). The 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) "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 used to measure progress toward achieving health equity

(c) "Social Determinants of Health and Equity" (SDOH-E).

(A) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age. 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) 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.

(e) "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 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) Supporting Health for All through Reinvestment Initiative (SHARE Initiative)

(B) Boosting Up Investment in Long-term Development for SDOH-HE Fund (BUILD Fund)

(3) The following general requirements apply to any SDOH-E spending program:

(a)CCOs shall select SDOH-E spending priorities based on:

(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.

(B) Any SDOH-E priority areas identified by the Authority.

(b) A portion of SDOH-E Spending Program expenditures 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 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) 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, and health-related services community benefit initiatives, as defined in OAR 410-141-3845. Interested CAC members—for example, a member whose employer is up for consideration as an SDOH-E partner—shall recuse themselves from the decision-making process.

(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 the CCO's efforts to align the CAC's composition with the CCO membership's demographic composition and CHP priorities. These reports will be posted publicly with appropriate redactions.

(8) Health Equity Infrastructure.

(a) CCOs shall develop and implement a "Health Equity Plan" to address health disparities that exist among the CCOs' members and, more generally, the communities within the CCOs' service areas. 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 cultural responsiveness, implicit bias, and anti-discrimination laws, in accordance with the Authority's standards.

(b) The health equity plan shall be submitted to the Authority for review and approval.

(c) CCOs shall designate a single point of accountability for health equity with budgetary decision-making authority and health equity expertise.

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 that all CCO members must have access to certified traditional health workers (THWs) who are part of the member's care team to improve access to appropriate services and participate in processes affecting the member's care and services. THW is defined in OAR 410-180-0305. 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;

(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 and standards issued by the Traditional Health Worker Commission, a payment model grid that defines sustainable THW payment levels and alternative payment strategies. The CCO shall make this payment model grid 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

Pursuant to OAR 410-141-38050, 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) 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) 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) 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 services enroll with the CCO serving the geographic area of placement. Child Welfare representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary.

(c) Children in OYA custody enroll 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) 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 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) Except for OAR 410-141-3805 and 410-141-3080, 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 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) 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) 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) 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) 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) 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) The development of a prior-authorized treatment plan;

(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.

(13) 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) Other just causes to preserve continuity of care include the following:

(A) Enrollment poses a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(14) 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) MCEs shall have open enrollment for 30 continuous calendar days during each twelve-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) If an MCE is assumed by another MCE, members shall be automatically enrolled in the succeeding MCE.

(a) Each member will have 30 calendar days to request disenrollment from the succeeding MCE.

(b) If the succeeding MCE 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) 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 Authority must notify members of a change in participating providers or MCEs, 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.

(b) In accordance with 42 CFR 438.56(c)(2), 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 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 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.

(iv) Members may request to change their MCE enrollment during OHP eligibility renewal, as defined in OAR 410-141-3805. The OHP eligibility period is typically 12 months.

(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 approved, 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) With cause, at any time, if any of the following situations apply.

(A) Due to moral or religious objections, the MCE does not cover the service the member seeks.

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

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

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the 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 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;

(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3805, or as defined in this rule. 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 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 exception during pregnancy.

(A) A temporary enrolment 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;

(ii) The member is newly re-determined eligible for OHP and not enrolled in a MCE within the past three months; or

(iii) The member is enrolled with a new 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 days postdate of delivery of the member's child, at which time the member shall select and be enrolled in the appropriate MCE plan in their service area.

(e) Member disenrollment requests under this subsection (2) are subject to the following requirements.

(A) The member shall join another MCE unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3805, or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another MCE 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 fraudulent or illegal acts related to the member's participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The 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 disenrollment for reasons other than an uncooperative or disruptive member shall comply with the requirements of this subsection (b).

(A) The MCO shall submit a written disenrollment request to the Coordinated Account Representative (CAR). 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.

(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:

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

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

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

(E) Documentation of 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;

(F) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the MCE shall attempt to locate another PCP on their panel who shall accept the member as their patient. If needed, the MCE shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be consistent with the MCE's OHP policies, the MCE or PCP's policies for commercial members, and applicable disability discrimination laws. The 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) Requests by the MCE for an exception to the routine 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 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 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 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.

(i) Providers shall immediately notify the MCE about the incident with the member. The notification shall describe the problem and shall be maintained for documentation purposes;

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

(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 a copy of the police report or case number. If a report is not available, the MCE shall submit a signed entry in the member's clinical 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.

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

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

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

(h) The following procedures apply to all approved disenrollment requests made by the MCE:

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

(B) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint as specified in OAR 410-141-3875 through 410-141-3905 and to request an administrative hearing 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;

(C) The disenrollment effective date shall be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an administrative law judge's decision to uphold disenrollment;

(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.

(6) Unless specified otherwise in these rules or in the Authority notification of disenrollment to the MCE, all disenrollment's 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 death.

(7) 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 has stopped accepting patients from or has terminated providing services to members in the transferring MCE;

(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 the provider's contract with their current MCE contractual relationship ends, or on a date approved by the Authority.

(c) Members may not be transferred under this section (8) unless the following conditions have been satisfied:

(A) The Authority has evaluated the receiving MCE and determined that the MCE meets criteria established by the Authority as stated in rule 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 days before the scheduled date of the transfer.

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

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) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO on the same day the individual is admitted to the residential treatment services, 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 individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(4) 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.

(5) 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.

(6) 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, dental, 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.

(7) 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) 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) 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 services specified by Statements of Intent or Guideline Notes which are included in the funded portion of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830. 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" 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 necessary and appropriate as defined in 410-120-0000and at the time they are provided, except that services shall also meet the prudent layperson standard defined in 410-141-3840.

(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 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 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.

(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services. Preventive services are covered if they appear in the funded portion of the Prioritized List of Health Services. 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 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.

(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).

(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;

(C) Community standards; and

(D) 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 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 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 funded treatment that do not pair on the HERC Prioritized List of Health Services and coverage is not otherwise available pursuant to this section, the member's MCE – or for fee for service, the medical review unit may seek a coverage determination from the Division

(b) If the Division determines that HERC has not considered the funded condition/treatment pair for inclusion on the Prioritized List, the Division shall make an ad hoc coverage determination in consultation with the HERC.

(c) If an MCE disagrees with the Division's coverage determination, the MCE may invoke the dispute resolution procedures in OAR 410-141-3550.

(14) General anesthesia for dental procedures. General anesthesia for dental procedures that are medically and dentally 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 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 by the client's primary care provider; or

(B) Urgent or emergency services; or

(C) Otherwise covered pursuant to rule or the MCE contract.

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 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://www.oregon.gov/OHA/HPA/CSI-HERC/Pages/Prioritized-List.aspx. For a hard copy, contact the Authority.

(2) This rule, effective January 1, 2019, 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 1, 2018, Prioritized List.

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

(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, 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 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;

(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, pharmacy and 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/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/time of the initial request for prior authorization as follows:

(I) If the drug is approved as requested, the MCE shall notify the member, 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, pharmacy and prescribing practitioner; and

(ii) If the requested additional documentation is not received within 72 hours from the date/time of the initial request for prior authorization, the MCE shall issue a written notice of adverse benefit determination to the member, 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 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 appropriate response as indicated to urgent or emergency calls including but 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.

(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 billed within ten calendar days of 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 health care.

(a) CCOs shall educate members about 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.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 42 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 with the priorities identified in the CCO's community health improvement plan. CCOs will align HRS community benefit initiatives spending with any HRS CBI 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 spending decisions.
(d) MCEs 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 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) 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.

(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 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; and

(C) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.

(b) "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) "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 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;

(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.

(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 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 services were prior authorized.

(8) The predecessor plan shall comply with requests from the receiving CCO for complete historical utilization data within 21 calendar days of the member's effective date with the receiving CCO.

(a) Data shall be provided in a HIPAA compliant format to facilitate continued access to care.

(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 (13), (14), and (15) of this rule;

(c) Drugs covered under Medicare Part D when the client 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 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) 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.

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

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

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

(c) Be made available in paper form if requested by a member; and

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

(6) The preferred drug list shall:

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

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

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

(7) MCEs shall cover at least one form of contraception within each of the eighteen 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) Prior authorization for prescription drug requests shall be addressed by the MCEs as described in OAR 410-141-3835.

(10) 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) 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

(12) 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) MCEs shall submit quarterly utilization data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.

(14) 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) 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 by 42 CFR 456, subpart K.

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 members integrated person-centered care and services, MCEs 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.

(2) MCEs 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 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;

(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 shall develop evidence-based, 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 shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs:

(a) 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 mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology where available;

(c) MCEs shall engage 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 implements other models of patient-centered primary health care in addition to the use of PCPCH, the MCE shall ensure member access to coordinated care services that provide effective

wellness and prevention, coordination of care, active management and support of individuals 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 shall:

(a) Demonstrate that 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 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 shall ensure the member has an ongoing source of primary care appropriate to their needs by formally designating a practitioner or entity;

(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 information on how to contact their designated person or entity;

(c) MCEs shall develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. MCEs shall ensure that all other services and supports are provided as close to the member's residence as possible.

(d) MCE members who are Indians shall be permitted to select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE or may select an out-of-network IHCP from whom the enrollee is otherwise eligible to receive such primary care services.

(7) MCEs shall establish hospital and specialty service agreements that include the role of patient-centered primary care homes 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 shall meet the following requirements relating to transitions of care:

(a) MCEs shall demonstrate how hospitals and specialty services shall be accountable to achieve successful transitions of care. MCEs shall 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) When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service to an MCE, the MCE 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 participating provider.

(c) The MCE shall 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 for members accessing care coordination.

(d) For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), the MCE shall notify the appropriate Department office and begin appropriate discharge planning. The MCE shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled in the MCE during the hospitalization preceding the nursing facility placement:

(A) MCEs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);

(B) For members who are discharged to Medicare Skilled Care, the MCE shall notify the appropriate Department office when the MCE 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;

(C) MCEs 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) MCEs 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 care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.

(9) MCEs 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:

(a) The MCE shall establish 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 services with long-term care services and crisis management services;

(b) MCEs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members receiving Medicaid-funded LTCSS;

(c) MCEs shall establish agreements 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 cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. (See OAR 410-141-3500 for the definition of an IMD.) The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):

(a) For members aged 21-64;

(b) As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;

(c) The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):

(A) The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;

(B) The MCE must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;

(C) The approved in lieu of services are authorized and identified in the MCE contract and may be offered to members at the MCE's option.

(11) If the member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the MCE 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 shall demonstrate that 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 shall also demonstrate ability to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities).

(a) MCE 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) (b).

(b) The MCE shall communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. MCEs shall document all monitoring and corrective action activities.

(13) MCEs 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 shall coordinate the care of members that 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 and are transitioning from the Oregon State Hospital.

(14) MCEs shall coordinate a member's care even when services or placements are outside the MCE 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 health services placements for services including residential placements may be located out of the service area; however, the MCE shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the MCE 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 shall be maintained in the county of origin with the expectation of the MCE to coordinate care with the out of area placement and local providers;

(b) The MCE shall coordinate the discharge planning when the member returns to the county of origin.

(c) 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) MCEs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the MCE's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The MCE shall pay 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 Service Authorization.

(17) MCEs 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 and to prevent inappropriate use of the emergency department or jails.

(18) MCEs shall perform care coordination in a manner that is trauma-informed and culturally responsive, as those terms are defined in OAR 309-035-0105.

(19) MCEs shall monitor the effectiveness of their integration and care coordination efforts. MCEs must implement at least 1 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) The MCE must report semiannually to the Authority on its care coordination activities. The MCE is subject to appropriate corrective action by the Authority if the contents of the report reveal that the MCE's care coordination requirements are not being met. The report must contain:

(a) An identification of care coordination practices used with members;

(b) An overall review of care coordinators performing services for the MCE, separated by employed and delegated or subcontracted care coordinators;

(c) Identification of any significant events that occurred to members;

(d) Data on frequency of 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 plan to improve the overall process of care coordination access for its Members. This 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 plan is subject to approval by the MCE board and must be updated semiannually with milestones and accomplishments.

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 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 shall conduct a health risk screening for each new member. This screening is distinct from the assessment of special health care needs.

(a) MCEs must use a universal screening process that assesses members for critical risk factors that trigger the need for intensive care coordination for high-needs members.

(b) Members shall be screened upon initial enrollment with the MCE. This screening shall be completed and documented as quickly as the member's health condition requires, but at least within 90 days of the effective date of enrollment for all new members, or within 30 days when the member is referred or is receiving Medicaid-funded long-term care, services, and supports or is a member of a priority population for ICC, as described in OAR 410-141-3870(2).

(c) Members shall be reassessed annually, upon a change in responsibility, or change in health status indicating need for an updated assessment.

(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 all completed assessments. If the MCE requires additional information from the member to complete an assessment, the MCE 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 shall share the results of its assessment, consistent with ORS 414.679 and applicable privacy requirements with:

(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) MCEs shall have processes to ensure review of a member's potential need for long-term services and supports and identify appropriate members for referrals to the Department for long-term services and supports.

(4) MCEs' care coordinators shall develop, and MCEs 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 needs, including members 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) A member's care plan must:

(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 specialized program, care plans must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if care plan needs change.

(6) Care plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals. Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered

(a) To ensure engagement and satisfaction with care plans, 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.

(c) Care coordinators shall actively engage members and caregivers 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 would be significantly detrimental to the member's care or health, a member may be excluded from the development of a care plan and denied access to a copy of the plan. The MCE must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts have been made to ameliorate the risk(s).

This decision must be reviewed prior to each plan update, and the decision to continue the exclusion must be documented as above.

(7) A member may decline care coordination and ICC. The MCE shall explicitly notify members that participation is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

(8) An MCE's care coordinators must 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) Set agreed-upon goals for the member with continued CCO network support for self-management goals;

(C) Promote utilization of preventive, early identification and intervention, and chronic disease management services;

(D) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;

(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) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and

(G) Have contact with the active program-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

(b) Care coordinators shall promote continuity of care and recovery management through:

(A) Shall continue through episodes of care, regardless of location of individual;

(B) Monitoring of conditions and ongoing recovery and stabilization;

(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;

(D) Engaging members, and their family and caregivers as appropriate.

(9) An MCE must facilitate transition planning for members. In addition to the requirements of 410-141-3860, care coordinators must take the following steps to facilitate transitions and ensure applicable services continue after discharge:

(a) The member's care coordinator must participate and play an active role in discharge planning from a specialized facility.

(b) For discharges from the State Hospital and residential care, the care coordinator shall have contact with the member no less than 2 times per month prior to discharge and 2 times within the week of discharge. Care coordinators must attempt to engage in a face-to-face warm handoff to relevant care providers during transition of care and discharge planning. The care coordinator shall also engage with the member, face to face, within 2 days post discharge.

(c) For discharges from an acute care admission, care coordinator shall have contact with the member within 1 business day of admission, 2 times a week while the member is in acute care, and no less than 2 times a week within the week of discharge, on a face-to-face basis if possible.

(d) Prior to discharge, CCOs will conduct a transition meeting to facilitate development of a transition plan. This meeting must be held prior to the member's return to the Contractor Service Area , 30 days prior to discharge, or as soon as possible if the MCE is notified of impending discharge or transition with fewer 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 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.

(f) The MCE must supervise care coordinators to ensure they are providing appropriate services and supports to members and provide full oversight and supervision to the assigned care coordinators. The individual tasked with such responsibility must 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 care coordinators responsible for ensuring integrated coordination of care.

410-141-3870 Intensive Care Coordination

1) MCEs are responsible for intensive care coordination (ICC) services. The requirements described herein are in addition to the general care coordination requirements 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 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) MCEs shall make ICC services available to members identified with special health care needs or as priority populations including; older adults; individuals who are blind, deaf, or hard of hearing or have other disabilities; members with complex medical needs, high health care needs, or multiple chronic conditions; those receiving Medicaid-funded long-term care, services, and supports; 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 in medication assisted treatment for substance use disorder; pregnant women and women with dependent children; IV drug users; individuals with HIV/AIDS; individuals with tuberculosis; veterans and their families; and individuals at risk of first episode psychosis. Children and youth 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 member, member's representative, HCBS provider, provider, or other medical personnel serving the member or the 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 established process for responding to such 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.

(b) MCEs shall reassess members for ICC eligibility, revise care plans if necessary and ensure care coordination after notice of any 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 month;

(L) Two or more caregiver placements within past 6 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 program.

(c) Member rescreening for ICC, and care plan revision, must be performed annually.

(d) Member rescreening for ICC, and care plan revision if necessary, must be performed upon member request.

(5) Members eligible for ICC shall be assigned a care coordinator.

(a) Care coordinator assignments must be made within 3 business days.

(b) If a member is in a specialized program at the time they are determined eligible for ICC, or enters a specialized program, then the MCE will appoint that care coordinator of the specialized program as the care coordinator for the member while the member is in the specialized program. After transition from the specialized program, the CCO must reassess the member within 7 days and assign a new care coordinator in accordance with the provisions above.

(c) The MCE shall notify the member of their ICC status by at least two means of communication within 5 business days following the screening. Notifications shall include details of the ICC program and the name and contact information of the care coordinator.

(6) MCEs shall implement procedures to share the results of screening identifications and treatment plans for ICC services with participating providers serving the member; other parties identified in OAR 410-141-DDDD; and, for members receiving Medicaid-funded LTCSS, APD and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements and meet timely access standards defined in 410-141-3515.

(6) ICC activities include:

(a) Early identification of members eligible for ICC services;

(b) 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) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to medical providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(8) Care coordinators performing ICC must carry out 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 every 3 months and make contact of any kind (face to face when possible)

3 times a month or more frequently if indicated. If unable to do so, the MCE must document attempts made, barriers, and efforts/plans to overcome barriers.

(b) Attempt to contact the member no more than 3 days after receiving notification of a reassessment trigger described in paragraph (3)(b) above. ICC care coordinators must continue brief contacts as long as deemed necessary by the care team.

(c) Contact the member's PCP within 1 month of ICC assignment, no less than once a month thereafter, or more often if required, 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, 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 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) Describe the clinical interventions recommended to the treatment team;

(B) Create a space for the Member to provide feedback on their care, self-reported progress towards their care 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 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) If a member is enrolled in other 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 specific needs based on their specialty within the interdisciplinary team.

(10) MCEs shall implement processes for documentation of ICC services and the development of a treatment plan for a member identified with special health care needs. MCEs 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. Each treatment 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 caring for the member and DHS long-term services and supports providers and case managers;

(c) Be approved by the MCE in a timely manner if MCE approval is required;

(d) In alignment with rules outlined in OAR 410-141-3835 MCE Service Authorization; and

(e) In accordance with any applicable quality assurance and utilization review standards.

(11) MCEs shall periodically inform all participating providers of the availability of ICC and other support services available for members and provide training for patient-centered primary care homes and other primary care providers' staff.

(12) MCE staff performing care coordination shall meet the following requirements:

(a) ICC care coordinators shall be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the MCE'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. If a Member is unable to receive services outside of normal business hours, the MCE shall provide alternative availability options for member.

(b) Staff who coordinate or provide ICC services shall be trained for, and exhibit skills in, person-centered care planning; and communication with and sensitivity to the unique health care needs of people who are aged, blind, or disabled or who have complex medical needs. MCEs shall have a written position description for the staff member(s) responsible for managing ICC services and for staff who provide ICC services.

(c) MCEs 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 care coordination staffing standards for that specialized group, if a lower ratio is called for.

(13) Consistent with OAR 410-141-3870, MCEs 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 shall provide alternative availability options for member.

(14) MCEs shall have a process to provide members in ICC who have special health care needs 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 about any matter other than an adverse benefit determination, as defined in OAR 410-120-0000. 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.

(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 42CFR §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 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 provide its decision related to oral grievances either orally or in writing 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.;

(d) Notifies 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 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 by the member stating he no longer wishes services or gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(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) The MCE shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution.

(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) 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 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.

(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) 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) 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) 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) 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 continuing benefits before the sooner of:

(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 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 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 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 transportation provider 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:

(a) Schedule NEMT services at least 24 hours in advance; and

(b) Schedule same-day NEMT services.

(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 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 a notice of action to a member denied a ride within 72 hours of denial.

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 with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, 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 transport members using wheelchairs or stretchers, if the member is using a wheelchair or stretcher.

(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; and

(b) 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 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 months of the date of hire and at least every three years thereafter;

(c) Completing 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;

(d) Completing the Passenger Service and Safety course or equivalent course within six 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.

(6) 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 the following circumstances:

(a) The member is receiving an OHP-covered health care service that is not available in the service area but is available in another area of the state;

(b) The member is receiving an OHP-covered service where the service location is 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,

(d) The member is receiving an OHP-covered service outside of Oregon that is not available in 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 years of age who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to children and young adults 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 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 (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 the parent or guardian authorizes it.

(6) CCOs may 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 CCO may not 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 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 both the Authority and the contiguous state have licensed the ambulance service provider.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625

410-141-3950 Transportation: Modifications for Individuals with Disabilities

(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:

(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.

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence that 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) CCO’s 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) 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 a direct threat to the driver, 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.

(f) Frequently cancels the ride on the day of the scheduled ride time.

(4) 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;

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(5) 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;

(c) Address health and safety concerns;

(6) The communications discussed in section (5) may include:

(a) The member's care team, at the request of the member or the CCO;

(b) Any another individual of the member's choosing.

(7) 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) A CCO may not modify NEMT services under this rule due solely to a request for modification or auxiliary aid based on disability or other protected class status.

(9) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.

(10) 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:

(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 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 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 years. The Authority may request this information at any time during the three-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