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OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Compliance with Medicaid Managed Care Rules-CMS 2390-F

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AMEND: 410-120-0000

RULE TITLE: Acronyms and Definitions

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: The revision of the Oregon Medicaid General and Administrative rules brings these rule into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:
Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3000 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division.
(1) “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.
(2) “Action” means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements.

For the definition as it is related to a CCO member, refer to OAR 410-141-3000.
(3) “Acupuncturist” means an individual licensed to practice acupuncture by the relevant state licensing board.
(4) “Acupuncture Services” means services provided by a licensed acupuncturist within the scope of practice as defined under state law.
(5) “Acute” means a condition, diagnosis, or illness with a sudden onset and that is of short duration.
(6) “Acquisition Cost” means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.
(7) “Addictions and Mental Health Division” means the Division within the Authority’s Health Systems Division that administers mental health and addiction programs and services.
(8) “Adequate Record Keeping” means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.
(9) “Administrative Medical Examinations and Reports” means examinations, evaluations, and reports, including copies of medical records requested on the OHP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.
(10) “Advance Directive” means an individual’s instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.
(11) “Adverse determination” means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.
(12) “Adverse Event” means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.
(13) “Aging and People with Disabilities (APD)” means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named “Seniors and People with Disabilities (SPD).”
(14) “All-Inclusive Rate” or “Bundled Rate” means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division’s Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.
(15) “Allied Agency” means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).
(16) “Alternative Care Settings” means sites or groups of practitioners that provide care to members under contract with an MCE, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.
(17) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.
(18) “Ambulatory Payment Classification” means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).
(19) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.
(20) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.
(21) “American Indian/Alaska Native (AI/AN) Clinic” means a clinic recognized under Indian Health Services (IHS) law or

by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).
(22) “Ancillary Services” means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.
(23) “Anesthesia Services” means administration of anesthetic agents to cause loss of sensation to the body or body part.
(24) “Appeal” means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.
(25) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.
(26) “Atypical Provider” means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.
(27) “Audiologist” means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.
(28) “Audiology” means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.
(29) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.
(30) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.
(31) “Behavioral Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.
(32) “Behavioral Health Case Management” means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.
(33) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.
(34) “Benefit Package” means the package of covered health care services for which the client is eligible.
(35) “Billing Agent or Billing Service” means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.
(36) “Billing Provider (BP)” means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.
(37) “Buying Up” means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)
(38) “By Report (BR)": means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.
(39) “Case Management Services” means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

(40) “Certified Traditional Health Worker” means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.
(41) “Child Welfare (CW)” means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.
(42) “Children's Health Insurance Program (CHIP)” means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.
(43) “Chiropractor” means an individual licensed to practice chiropractic by the relevant state licensing board.
(44) “Chiropractic Services” means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.
(45) “Citizen/Alien-Waived Emergency Medical (CAWEM)” means aliens granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210(4)(d).
(46) “Claimant” means an individual who has requested a hearing.
(47) “Client” means an individual found eligible to receive OHP health services.
(48) “Clinical Nurse Specialist” means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.
(49) “Clinical Social Worker” means an individual licensed to practice clinical social work pursuant to state law.
(50) “Clinical Record” means the medical, dental, or mental health records of a client or member.
(51) “Co-morbid Condition” means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.
(52) “Comfort Care” means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.
(53) “Community Health Worker” means an individual who:
(a) Has expertise or experience in public health;
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;
(f) Provides health education and information that is culturally appropriate to the individuals being served;
(g) Assists community residents in receiving the care they need;
(h) May give peer counseling and guidance on health behaviors; and
(i) May provide direct services such as first aid or blood pressure screening.
(54) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.
(55) “Condition/Treatment Pair” means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.
(56) “Contested Case Hearing” means a proceeding before the Authority under the Administrative Procedures Act

when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:
(a) A client or member or their representative;
(b) A member of an MCE after resolution of the MCE's appeal process;
(c) An MCE member's provider; or
(d) An MCE.
(57) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.
(58) "Contiguous Area Provider" means a provider practicing in a contiguous area.
(59) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.
(60) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3000.
(61) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)
(62) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.
(63) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:
(a) Ancillary services (OAR 410-141-0480);
(b) Diagnostic services necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition;
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k;
(d) 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).
(64) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.
(65) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.
(66) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.
(67) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.
(68) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.
(69) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.
(70) "Dental Services" means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.
(71) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which he or she

practices dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.
(72) “Denturist” means an individual licensed to practice denture technology pursuant to state law.
(73) “Denturist Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.
(74) “Dental Hygienist” means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.
(75) “Dental Hygienist with an Expanded Practice Permit” means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.
(76) “Dentally Appropriate” means health services, items, or dental supplies:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and
(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE’s judgement;
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.
(77) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.
(78) “Department Representative” means an individual who represents the Department and presents the Department’s position in a hearing.
(79) “Diagnosis Code” means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.
(80) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-10-CM.
(81) “Diagnostic Services” mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.
(82) “Division (Division)” means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.

(83) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.
(84) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.
(85) “Electronic Data Interchange (EDI)” means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other

formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.
(86) “EDI Submitter” means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.
(87) “Electronic Verification System (EVS)” means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.
(88) “Emergency Department” means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.
(89) “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(4)(d)(C).
(90) “Emergency Medical Transportation” means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.
(91) “Emergency Services” means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.
(92) “Evidence-Based Medicine” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation [sic] of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings.
(93) “False Claim” means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information would result, or has resulted, in an overpayment.
(94) “Family Planning Services” means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.
(95) “Federally Qualified Health Center (FQHC)” means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.
(96) “Fee-for-Service Provider” means a health care provider who is not reimbursed under the terms of an Authority

contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.
(97) “Fraud” means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.
(98) “Fully Dual Eligible” means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.
(99) “General Assistance (GA)” means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.
(100) “Grievance” means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested.
(101) “Health Care Interpreter” Certified or Qualified have the meaning given those terms in ORS 413.550.
(102) “Health Care Professionals” means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.
(103) “Healthcare Common Procedure Coding System (HCPCS)” means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.
(104) “Health Evidence Review Commission” means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.
(105) “Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)” means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
(106) “Health Maintenance Organization (HMO)” means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.
(107) “Health Plan New/non-categorical client (HPN)” means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.
(108) “Hearing Aid Dealer” means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.
(109) “Home Enteral Nutrition” means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.
(110) “Home Health Agency” means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.
(111) “Home Health Services” means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(112) “Home Intravenous Services” means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.
(113) “Home Parenteral Nutrition” means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.
(114) “Hospice” means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.
(115) “Hospital” means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.
(116) “Hospital-Based Professional Services” means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (division 42) report for the Division.
(117) “Hospital Dentistry” means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).
(118) “Hospital Laboratory” means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital’s cost report to Medicare and to the Division.
(119) “Indian Health Care Provider” (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603.
(120) “Indian Health Program” means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.
(121) “Indian Health Service (IHS)” means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.
(122) “Indian Managed Care Entities” (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.
(123) “Indigent” means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in 813.602(5).
(124) “Individual Adjustment Request Form (OHP 1036)” means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.
(125) “Inpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)
(126) “Institutional Level of Income Standards (ILIS)” means three times the amount SSI pays monthly to a person who

has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.
(127) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.
(128) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.
(129) "Joint fair hearing request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in § 435.1200(b)(3).
(130) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).
(131) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his or her scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.
(132) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.
(133) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.
(134) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.
(135) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:
(a) "Long-term Care" as defined in OAR 461-001-0000 means 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 Behavioral Health, including state psychiatric hospitals;
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).
(136) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.
(137) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making

reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).
(138) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.
(139) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.
(140) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.
(141) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.
(142) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).
(143) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.
(144) "Medical Transportation" means transportation to or from covered medical services.
(145) "Medically Appropriate" means health services, items, or medical supplies that are:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and
(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.
(146) "Medically Necessary" means health services and items that are required by a client or member to address one or more of the following:
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;
(b) The ability for a client or member to achieve age-appropriate growth and development;
(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;
(e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically necessary services are covered services.
(147) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.
(148) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.
(149) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.
(150) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.
(151) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.
(152) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.
(153) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.
(154) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.
(155) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.
(156) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:
(a) OAR 410-120-1200 Excluded Services and Limitations; and
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;
(c) OAR 410-141-0480 OHP Benefit Package of Covered Services;
(d) OAR 410-141-0520 Prioritized List of Health Services; and
(e) Any other applicable Division administrative rules.
(157) "Non-Emergent Medical Transportation Services (NEMT)"means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.
(158) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).
(159) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.
(160) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.
(161) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

(162) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.
(163) “Nursing Services” means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.
(164) “Nutritional Counseling” means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.
(165) “Occupational Therapist” means an individual licensed by the State Board of Examiners for Occupational Therapy.

(166) “Occupational Therapy” means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.
(167) “Ombudsman Services” means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.
(168) “Oregon Health ID” means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.
(169) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan
(170) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.
(171) “Optometrist” means an individual licensed to practice optometry pursuant to state law.
(172) “Oregon Health Authority (Authority)” means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.
(173) “Oregon Youth Authority (OYA)” means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.
(174) “Out-of-State Providers” means any provider located outside the borders of the State of Oregon:
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.
(175) “Outpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division’s Hospital Services administrative rules chapter 410, division 125.
(176) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.
(177) “Overpayment” means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.
(178) “Overuse” means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.
(179) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.
(180) “Payment Authorization” means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.
(181) “Peer Review Organization (PRO)” means an entity of health care practitioners of services contracted by the state

to review services ordered or furnished by other practitioners in the same professional field.
(182) “Peer Support Specialist” including Family Support Specialist and Youth Support Specialist has the meaning given that term in OAR 410-180-0305.
(183) “Peer Wellness Specialist” including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual’s peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.
(184) “Person Centered Care” means care that reflects the individual patient’s strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient’s goals, and will assist the patient in achieving the goals.
(185) “Personal Health Navigator” means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient’s particular circumstances and in light of the patient’s needs, lifestyle, combination of conditions, and desired outcome.
(186) “Pharmaceutical Services” means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.
(187) “Pharmacist” means an individual licensed to practice pharmacy pursuant to state law.
(188) “Physical Capacity Evaluation” means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.
(189) “Physical Therapist” means an individual licensed by the relevant state licensing authority to practice physical therapy.
(190) “Physical Therapy” means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.
(191) “Physician” means an individual licensed to practice medicine pursuant to state law of the state in which he or she practices medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.
(192) “Physician Assistant” means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.
(193) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.
(194) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.

(195) “Podiatrist” means an individual licensed to practice podiatric medicine pursuant to state law.
(196) “Post-Payment Review” means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.
(197) “Practitioner” means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.
(198) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)
(199) “Primary Care Dentist (PCD)” means a dental practitioner responsible for supervising and coordinating initial and

primary dental care within their scope of practice for their members.
(200) “Primary Care Provider (PCP)” means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.
(201) “Prior Authorization (PA)” means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.
(202) “Prioritized List of Health Services” means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.
(203) “Private Duty Nursing Services” means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.
(204) “Provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.
(205) “Provider Organization” means a group practice, facility, or organization that is:
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)
(206) “Psychiatric Emergency Services (PES)” means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.
(207) “Public Health Clinic” means a clinic operated by a county government.
(208) “Public Rates” means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.
(209) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.
(210) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.
(211) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.
(212) “Quality Improvement Organization (QIO)” means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.
(213) “Radiological Services” means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.
(214) “Recipient” means an individual who is currently eligible for medical assistance (also known as a client).

(215) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).
(216) “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.
(217) “Referral” means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.
(218) “Remittance Advice (RA)” means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.
(219) “Rendering provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.
(220) “Request for Hearing” means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.
(221) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.
(222) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.
(223) “Ride” means non-emergent medical transportation services for a client either to or from a location where covered services are provided. “Ride” does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.
(224) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.
(225) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.
(226) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.
(227) “Self-Sufficiency” means the division in the Department of Human Services that administers programs for adults and families.
(228) “Service Agreement” means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.
(229) “Sliding Fee Schedule” means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.
(230) “Social Worker” means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.
(231) “Speech-Language Pathologist” means an individual licensed by the Oregon Board of Examiners for Speech Pathology.
(232) “Speech-Language Pathology Services” means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.
(233) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(234) “Subparts (of a Provider Organization)” means for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.
(235) “Subrogation” means right of the state to stand in place of the client in the collection of third party resources (TPR).
(236) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).
(237) “Supplemental Security Income (SSI)” means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.
(238) “Surgical Assistant” means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.
(239) “Suspension” means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds will be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.
(240) “Targeted Case Management (TCM)” means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.
(241) “Termination” means a sanction prohibiting a provider's participation in the Division’s programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless:
(a) The exceptions cited in 42 CFR 1001.221 are met; or
(b) Otherwise stated by the Authority at the time of termination.
(242) “Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer” means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.
(243) “Transportation” means medical transportation.
(244) “Service Authorization Request” means a member’s initial or continuing request for the provision of a service including member requests made by their provider or the member’s authorized representative.
(245) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.
(246) “Type B AAA” means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.
(247) “Type B AAA Unit” means a Type B AAA funded by Oregon Project Independence (OPI), Title III—Older Americans Act, and Title XIX of the Social Security Act.
(248) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.
(249) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.
(250) “Urgent Care Services” means health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of unforeseen illness or injury.
(251) “Usual Charge (UC)” means the lesser of the following unless prohibited from billing by federal statute or regulation:
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.
(252) “Utilization Review (UR)” means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.
(253) “Valid Claim” means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and
(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).
(254) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.
(255) “Vision Services” means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.
(256) “Volunteer” (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-120-0250

RULE TITLE: Managed Care Entity

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To align FFS Medicaid care coordination rule with managed care rules and to update entity reference to “MCE.”

RULE TEXT:
(1) The Authority provides clients with health services through contracts with a Managed Care Entity (MCE).
(2) The MCE is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law, the PHP or CCO's contract with the Authority, and the OHP administrative rules governing MCEs (OAR chapter 410 division 141).
(3) All MCEs are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520; however, authorization criteria may vary between MCEs. It is the providers' responsibility to comply with the MCE's Prior Authorization requirements or other policies necessary for reimbursement from the MCE before providing services to any OHP client enrolled in an MCE.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065, 414.631, 414.651

AMEND: 410-120-1280

RULE TITLE: Billing

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Cross over claim requirements TPL claim requirement adjustments.

RULE TEXT:

(1) A provider enrolled with the Authority or providing services to a client in an MCE under the Oregon Health Plan (OHP) may not seek payment from the client for any services covered by Medicaid fee-for-service or through contracted health care plans:

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

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

(2) For Medicaid covered services, the provider may not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division program rules.

(3) Providers shall only bill a client or a financially responsible relative or representative of that client in the following situations:

(a) For any applicable coinsurance, copayments, and deductibles expressly authorized in OAR chapter 410, divisions 120 and 141, or any other Division program rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in an MCE, or third party insurance coverage at the time of or after a service was provided; therefore, the provider could not bill the appropriate payer for reasons including but not limited to the lack of prior authorization or the time limit to submit the claim for payment has passed. The provider must verify eligibility pursuant to OAR 410-120-1140 and document attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service;

(d) A third party payer made payments directly to the client for services provided;

(e) The client has the limited Citizen Alien Waived Emergency Medical benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits. (See OAR 410-120-1210 for coverage.) The provider must document that the client was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is not required for these services;

(f) The client has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, MCE, or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service;

(D) The provider documents in writing, signed by the client or the client's representative, indicating that the provider gave the client the information described in section (3)(g)(A-C); that the client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and that the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above.

The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Division or to the client's MCE or third party payer that is subject to the agreement.
(h) A provider may bill a client for services that are not covered by the Division, MCE (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165) or a facsimile containing all of the information and elements of the OHP 3165 as shown in Table 3165 of this rule. The completed OHP 3165 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed OHP 3165 or facsimile available to the Division or MCE upon request.
(4) Code Set requirements:
(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions, and payments. Code Set has the meaning set forth in 45 CFR 162.103, and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory, and the Division lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;
(b) The Division shall adhere to the Code Set requirements in 45 CFR 162.1000–162.1011;
(c) Periodically, the Division shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service;
(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone may not be construed as coverage or a covered service by the Division;
(e) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS). This code adoption may not be construed as coverage or as a covered service by the Division.
(5) Claims:
(a) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;
(b) A provider enrolled with the Division must bill using the Authority assigned provider number, or the National Provider Identification (NPI) number if the NPI is available, pursuant to OAR 410-120-1260;
(c) The provider may not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division program rules;
(d) Claims must be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR chapter 943, division 120;
(e) Medicare will send crossover claims to the Authority or contracted health plan after adjudication by Medicare. This requires claims sent to Medicare for primary payment to include the applicable information for all dually eligible Medicaid/Medicare members so that claims can automatically cross-over electronically to the Authority or to contracted health care plans. Medicare shall automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Division or the contracted health plan;
(f) Claims must be for services provided within the provider's licensure or certification;
(g) Unless otherwise specified, claims must be submitted after:
(A) Delivery of service; or
(B) Dispensing, shipment or mailing of the item.
(h) The provider must submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;
(i) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements;

(j) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:
(A) Any false claim for payment;
(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;
(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exception of (8)(c)(A-D) below. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Division. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code;
(D) Any claim for furnishing specific care, items, or services that has not been provided.
(k) If an overpayment has been made by the Division, the provider is required to do one of the following:
(A) Submit an Individual Adjustment Request; or
(B) Refund the amount of the overpayment on any claim; or
(C) Void the claim via the provider web portal if the reason for the overpayment was an erroneous billing;
(D) If the overpayment occurred because of a payment from a third party payer refer to (8)(f) of this rule.
(L) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued improper billing practices and has had an opportunity for a contested case hearing shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of the violation.
(6) Diagnosis code requirement:
(a) A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;
(b) The primary diagnosis code must be the code that most accurately describes the client's condition;
(c) All diagnosis codes are required to the highest degree of specificity;
(d) Hospitals must follow national coding guidelines and bill using the 7th digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.
(7) Procedure code requirement:
(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;
(b) For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be the code that most accurately describes the services provided. Hospitals must follow national coding guidelines;
(c) When there is no appropriate descriptive procedure code to bill the Division, the provider must use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider must bill the Division using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.
(8) Third party Liability (TPL):
(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division shall be the payer of last resort;
(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule, "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:
(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;
(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing;
(C) Asking the Medicaid recipient at the point of service or prior to billing if they have other health insurance;
(D) If the provider identifies from the client or other source third party insurance that is unknown to the state or that is different from what is reported in one of the Division verification systems, the provider must report the coverage to the

Health Insurance Group (HIG) using the secure online form at www.reporttpl.org.
(c) Except as noted in section (8)(d)(A through E) below, when third party coverage is known to the provider prior to billing the Division, the provider must:
(A) Bill all third party insurance the client is covered by, which could include Personal Insurance Protection (PIP) or Workers Compensation if the claim is related to a personal injury; and
(B) Except for pharmacy claims billed through the Division's point-of-sale system, the provider must wait 30 days from submission date of a clean claim and have not received payment from the third party; and
(C) Comply with the insurer's billing and authorization requirements; and
(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.
(d) In accordance with federal regulations, the provider must bill the TPL prior to billing the Division, except under the following circumstances:
(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);
(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;
(C) The covered health services are prenatal and preventive pediatric services;
(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;
(E) When a negligent third party caused an injury or illness to a client, a provider may choose to bill the Liability Insurance (see definition), bill the liable third party, place a lien on a tort settlement or judgement, or bill the Division. The provider may not both place a lien against a settlement and bill the Division:
(i) The provider may withdraw their lien and bill the Division within 12 months of the date of service; however, the provider must accept the Division payment as payment in full;
(ii) The provider may not return the payment made by the Division in order to place a lien or to accept payment from a liability settlement, judgement, liability insurer, or other source.
(F) In the circumstances outlined in section (8)(d)(A) through (E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the Division's allowable rate for these services and seek reimbursement from the liable third party insurance plan;
(G) In making the decision to bill the Division, the provider shall be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than the Division and that once the Division makes payment, no additional billing to the third party is permitted by the provider.
(e) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;
(f) In the case of known third party coverage, a provider may bill the Division if payment from the third party coverage is not received within 30 days. If a payment is received from the third party coverage after receiving the Division payment, the provider shall do one of the following within 30 days of receiving the payment:
(A) Submit an Individual Adjustment Request (OHP 1036) that shows the amount of the third party payment as a credit in the appropriate field; or
(B) Submit a claim adjustment online at https://www.or-medicaid.gov/ProdPortal/ that shows the amount of the third party payment as a credit in the appropriate field; or
(C) Refund the amount paid by the Division. The amount refunded shall be the lesser of the third party payment or the amount paid by the Division. The check to repay the Division shall include the reason the payment is being made and either:
(i) An Individual Adjustment Request that identifies the original claim, name and number of the client, date of service, and items or services for which the repayment is made; or
(ii) A copy of the Remittance Advice showing the original Division payment.

(D) Failure to submit the Individual Adjustment Requests within 30 days of receipt of the third party payment or to refund the Division payment is considered concealment of material facts and is grounds for recovery and sanction.
(E) Any provider who accepts payment from a client or client's representative and is subsequently paid for the service by the Division shall reimburse the client or their representative the full amount of their payment.
(g) If the third party coverage is not known by the Division or the provider at the time the Division makes payment, a provider may not return the Division payment in order to bill the third party coverage if the third party coverage becomes known after the Division payment;
(h) The Division may make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursuing alternate resources includes but is not limited to requesting the provider to bill the third party and to refund the Division in accordance with this rule;
(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, except as noted in 410-141-3420, and the provider must honor that request. Claims submitted to Medicare shall include the Medicaid information necessary to enable electronic crossover to the Authority or contracted health plan. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;
(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued, and Medicare denial must be obtained prior to submitting the claim for payment to the Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.
(9) Full use of alternate resources:
(a) The Division shall generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;
(b) Except as provided in section (10) of this rule, alternate resources may be available:
(A) Under a federal or state worker's compensation law or plan;
(B) For items or services furnished by reason of membership in a prepayment plan;
(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity such as:
(i) Armed Forces Retirees and Dependents Act (CHAMPVA);
(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); or
(iii) Medicare Parts A and B.
(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or
(E) Through other reasonably available resources.
(10) Exceptions:
(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort and are not considered an alternate resource or TPL;
(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPL.
(11) Table 120-1280 – TPR codes.
(12) Table – OHP Client Agreement to Pay for Health Services, OHP 3165.
[NOTE: Tables referenced are not included in rule text. Click here for PDF copy of tables.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

Table 120-1280 – Third Party Resource (TPR) Explanation Codes

Use in Field "9" on the CMS-1500

Single Insurance Coverage Use when the client has only one insurance policy in addition to DMAP coverage.	
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Client
RP	Requested Information Not Received by Insurance from Policy holder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance mandated under administrative/court order through an absent parent not paid within 30 days
OT	Other (if above codes do not apply, include detailed information of why no TPR payment was made)
Multiple Insurance Coverage Use when the client has more than one insurance policy in addition to DMAP coverage.	
MP	Primary Insurance Paid-Secondary Paid
SU	Primary Insurance Paid - Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid - Secondary Service Not Covered
SC	Primary Insurance Paid - Secondary Patient Not Covered
ST	Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
SL	Primary Paid - Secondary Lapsed or Not in Effect
SP	Primary Paid - Secondary Payment Went to Patient
SH	Primary Paid - Secondary Payment Went to Policyholder
SA	Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
SE	Primary Paid - Secondary Denied - Service Not Considered Emergency
SF	Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Paid - Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed information of why no TPR payment was made)

OHP Client Agreement to Pay for Health Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, *services* include, but are not limited to, health treatment, equipment, supplies and medications.

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the provider who is providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Service(s) requested:

Service codes *(CDT/CPT/HCPCS/NDC)*:

③ Expected date(s) of service *(if services are to occur over several months, please list the frequency, beginning and expected end dates):*

④ Condition being treated:

⑤ Estimated fees $ To $. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of the service(s).

☐ There may be other costs that are part of the service(s) and you may have to pay for them, too. Other procedures that usually are part of the service(s) may include the following (*check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other:

⑥ ☐ As the rendering or prescribing provider:

- I have tried all reasonable covered treatments for your condition.
- I have verified that the proposed service(s) are not covered.
- I have informed you of covered treatments for your condition, and you have selected a treatment that is not covered.

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.

☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: NPI:

Provider signature: Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand:

- That the services listed above are not covered for payment by OHP, my CCO or managed care plan.
- If I get the services above I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- I have read the back of this form and understand my other options.

I have been fully informed by the provider of all available medically appropriate treatment, including services that may be paid for by the Oregon Health Authority (OHA) or OHA-contracted CCOs or managed care plans, and I still choose to get the specified service(s) listed above.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

Client – Keep a copy of this form for your records.

Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your Coordinated Care Organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to make sure the service is not covered***

OHA, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and or Hearing***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html.

AMEND: 410-120-1860

RULE TITLE: Contested Case Hearing Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To align FFS Medicaid rule with 2390-F CFR Medicaid CFRs on Contested Case Hearings.

RULE TEXT:

(1) These rules apply to all contested case hearings provided by the Authority involving a client's health care benefits, except as otherwise provided in OAR 410-141-3245. The hearings are conducted in accordance with ORS 183.411 to 183.497 and the Attorney General's model rules, OAR 137-003-0501 to 137-003-0700. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Authority for purposes of this rule except for OAR 137-003-0528(1)(a). The method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of client requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Authority contested cases.

(2) Medical provider appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.

(3) Grievance, complaints, and appeals for clients requesting or receiving medical assistance from an MCE shall be governed exclusively by the procedures in OARs 410-141-0230 to 410-141-3255. This rule describes the procedures applicable when MCE clients request and are eligible for an Authority contested case hearing.

(4) Contested Case Hearing Requests:

(a) A client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Authority makes an adverse determination or action or , as it relates to an MCE, an adverse benefit determination such as denial of client services, payment of a claim, or to terminate, discontinue, or reduce a course of treatment, or issues related to disenrollment in an MCE; or

(B) The right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-3240 when a client of an MCE may request a state hearing.

(b) To be timely, a request for a hearing is complete when the following requirements are met:

(A) The Authority receives the Authority approved appeal and hearing forms not later than the 60th day following the date of the decision notice;

(B) When enrolled in an MCE, the member files the request for contested case hearing within the time frames specified in OAR 410-141-3247.

(c) In the event a request for hearing is not timely, the Authority shall determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7), for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Authority requires the request to be supported by a written statement that explains why the request for hearing is late. The Authority may conduct such further inquiry as the Authority deems appropriate. If the Authority finds that the client has good cause for late filing, the Authority shall refer the case to the OAH for a contested case hearing. The following factual disputes shall be referred to the OAH for a hearing:

(A) Whether the hearing request was received timely;

(B) Whether the client received the notice of adverse benefit determination or action;

(C) The information included in the client’s statement of good cause.

(d) In the event the claimant is not entitled to a contested case hearing on an issue, the Authority may enter an order accordingly. The Authority may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of an MCE, the claimant's MCE;

(f) A client may be represented by any of the individuals identified in ORS 183.458. An MCE that is a corporation may be represented by any of the individuals identified in ORS 410.190.
(g) For clients enrolled in an MCE, the following applies:
(A) May request a contested case hearing with the state after receiving notice that the adverse benefit determination or MCE action is upheld or, in the case of an MCE that fails to adhere to the notice and timing requirements, the state may deem that the member has exhausted the MCE's appeals process and may initiate a state contested case hearing pursuant to OAR 410-141-3247(3);
(B) A request for Authority administrative hearing made prior to an MCE appeal by the member or member's representative or provider shall be forwarded by the Authority to the MCE for review, except in the case where the Authority determines the MCE failed to act within required timelines.
(5) Expedited hearings:
(a) A claimant who feels his or her health care problem cannot wait for the normal review process may be entitled to an expedited hearing;
(b) Expedited hearings are requested using Authority Form 443 or other Division approved appeal and/or hearing request forms;
(c) Authority staff shall request all relevant health care documentation and present the documentation obtained in response to that request to the Authority medical director or the medical director's designee for review. The Authority medical director or designee shall decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;
(d) An expedited hearing shall be allowed if the Authority medical director or the designee determines that the claimant has a health care condition that could jeopardize the claimant's life, health, or ability to maintain or regain maximum function and claimant has been denied a health care service;
(e) Expedited hearing requests shall be completed as expeditiously as the enrollee's health condition requires with the following timelines:
(A) For expedited hearing requests responding to any claim requiring review of an MCE written notice of expedited appeal resolution, hearing requests shall be no later than three working days after the agency receives from the MCE the case file and information for any appeal of a denial of a service as indicated by the MCE;
(B) For expedited state contested hearing requests, no later than seven working days after the agency receives a request for expedited fair hearing responding to any request for the following reasons:
(i) Claim for services is denied or is not acted upon with reasonable promptness;
(ii) Requests because the claimant believes the agency has taken an action erroneously;
(iii) Requests because the claimant believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged;
(iv) Requests because the claimant believes the state has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act; or
(v) For expedited state administrative hearing for claims related to prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under CFR §435.912, based on the date the application is submitted to any insurance affordability program.
(f) The Authority shall take final administrative action on a contested hearing request within the time limits set forth in 42 CFR Part 431 and Part 435 except in unusual circumstances when:
(A) The Authority cannot reach a decision because the appellant requests a delay or fails to take a required action; or
(B) There is an administrative or other emergency beyond the Authority's control.
(6) Informal conference:
(a) The Authority hearing representative and the claimant, and their legal representative if any, may have an informal conference without the presence of the Administrative law Judge (ALJ) to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:
(A) Provide an opportunity for the Authority and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is the subject of the hearing request;
(C) Give the claimant and the Authority an opportunity to review the information that is the basis for that action;
(D) Inform the claimant of the rules that serve as the basis for the contested action;
(E) Give the claimant and the Authority the chance to correct any misunderstanding of the facts;
(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and
(G) Give the Authority an opportunity to review its action.
(b) The claimant may at any time prior to the hearing date request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds in his or her sole discretion that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;
(c) The Authority may provide to the claimant the relief sought at any time before the Final Order is served;
(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.
(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Authority or the ALJ, whichever is first. The ALJ shall send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth day following the date such an order is effective.
(8) Contested case hearings are closed to non-participants in the hearing; however, a client may choose to have another individual present.
(9) Proposed and Final Orders:
(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings shall serve a proposed order on all parties and the Authority, unless prior to the hearing the Authority notifies the ALJ that a final order may be served. The proposed order issued by the ALJ shall become a final order if no exceptions are filed within the time specified in subsection (b) below, unless the Authority notifies the parties and the ALJ that the Authority shall issue the final order;
(b) If the ALJ issues a proposed order, a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Authority's consideration:
(A) The exceptions must be in writing and reach the Authority not later than ten working days after date the proposed order is issued by the ALJ;
(B) After receiving the exceptions, if any, the Authority may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority shall issue an amended proposed order.
(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Authority shall cancel the dismissal order on request of the party upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were unable to attend the hearing and unable to request a postponement.
(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When the claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.
(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.
[NOTE: Forms referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: 183.341, 413.042

STATUTES/OTHER IMPLEMENTED: 183.411 - 183.471, 411.408, 414.025, 414.065

AMEND: 410-120-1865

RULE TITLE: Denial, Reduction, or Termination of Services

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To align FFS Medicaid rule with 2390-F CFR Medicaid CFRs and managed care revisions related to Denial, Reduction, or Termination of Services.

RULE TEXT:

(1) The purpose of this rule is to describe the requirements governing the denial, reduction, or termination of medical assistance and access to the Authority administrative hearings process for clients requesting or receiving medical assistance services paid for by the Authority on a fee-for-service basis. Grievance, complaint, and appeal procedures for clients receiving services from an MCE shall be governed exclusively by the procedures in OAR 410-0141-3260 and where applicable OAR 410-141-3475.

(2) When the Authority authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend, or reduce the course of treatment or a covered service, the Authority or its designee shall mail a written notice to the client at least ten days before the date of the termination or reduction of the covered service unless there is documentation that the client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written client notice must inform the client of the action the Authority has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Authority for additional information. The Authority is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4) The Authority shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the client requests an administrative hearing before the effective date of the client notice and requests that the services be continued, the Authority shall continue the services. The service shall be continued until whichever of the following occurs first, but may not exceed ninety days from the date of the client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The client is no longer eligible for medical assistance benefits or the health service, supply, or item that is the subject of the administrative hearing is no longer a covered benefit in the client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy, and the Authority promptly informs the client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the client in writing that it is continuing the service. The notice shall inform the client that if the hearing is resolved against the client, the cost of any services continued after the effective date of the client notice may be recovered from the client pursuant to 42 CFR 431.230(b);

(c) The Authority shall reinstate services if:

(A) The Authority takes an action without providing the required notice and the client requests a hearing;

(B) The Authority does not provide the notice in the time required under section (2) of this rule and the client requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the client, but the client's whereabouts become known during the time the client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision, unless at the hearing it is determined that the sole issue is one of federal or state law or policy.

(d) The Authority shall promptly correct the action taken up to the limit of the original authorization, retroactive to the

date the action was taken, if the hearing decision is favorable to the client, or the Authority decides in the client's favor before the hearing.

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 411.408, 414.025, 414.065

REPEAL: 410-141-0000

RULE TITLE: Definitions

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules brings these rule into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

In addition to the definitions in OAR 410-120-0000, the following definitions apply:

(1) "Action" means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(a) The denial or limited authorization of a requested service including the type or level of service;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial in whole or in part of payment for a service;

(d) The failure to provide services in a timely manner as defined by the Health Systems Division, Medical Assistance Programs (Division);

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

(f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:

(A) From any other provider (in terms of training, experience, and specialization) not available within the network;

(B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;

(C) Because the only plan or provider available does not provide the service due to moral or religious objections;

(D) Because the member's provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or

(E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.

(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final CCO or MCO claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

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

(4) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.

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

(6) "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.

(7) "Client" has the meaning given that term in OAR 410-120-0000.

(8) "Cold Call Marketing" means a PCP's or CCO's unsolicited personal contact with a potential member for the purpose of marketing.

(9) "Community Advisory Council" 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.

(10) "Community Standard" means typical expectations for access to the health care delivery system in the member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs take into consideration the community standard and be adequate to meet the needs of the Division.

(11) “Contract” means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.
(12) “Converting MCO” means a CCO that:
(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;
(b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.
(13) “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 Oregon Health 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.
(14) “Coordinated Care Services” mean a CCO’s fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.
(15) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.
(16) “Dental Care Organization (DCO)” means a PHP that provides and coordinates dental services as capitated services under OHP.
(17) “Dental Case Management Services” means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.
(18) “DCBS Reporting CCO” means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.
(19) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection agency.
(20) “Disenrollment” means the act of removing a member from enrollment with a PHP or CCO.
(21) “Exceptional Needs Care Coordination (ENCC)” means for PHPs a specialized case management service provided by FCHPs to members identified as aged, blind, or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes:
(a) Early identification of those members who are aged, blind, or disabled who have complex medical needs;
(b) Assistance to ensure timely access to providers and capitated services;
(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;
(d) Assistance to providers with coordination of capitated services and discharge planning; and
(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.
(22) “Enrollment” means the assignment of a member to a PHP or CCO for management and receipt of health services.
(23) “Free-Standing Mental Health Organization (MHO)” means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.
(24) “Fully-Capitated Health Plan (FCHP)” means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.
(25) “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.
(26) “Grievance” means a member’s complaint to a PHP, CCO, or to a participating provider about any matter other than an action.
(27) “Grievance System” means the overall system that includes:
(a) Grievances to a PHP or CCO on matters other than actions;
(b) Appeals to a PHP or CCO on actions; and
(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a

hearing by rule or state statute.
(28) “Health Services” means:
(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;
(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.
(29) “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.
(30) “Home CCO” means enrollment in a CCO in a given service area based upon a client’s most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization.
(31) “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.
(32) “Intensive Case Management (ICM)” means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including:
(a) Early identification of members eligible for ICM services;
(b) Assistance to ensure timely access to providers and capitated services;
(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;
(d) Assistance to providers with coordination of capitated services and discharge planning; and
(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
(33) “Licensed Health Entity” means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.
(34) “Line Items” means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.
(35) “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, managed care organizations, prepaid health plans, and primary care case managers.
(36) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.
(37) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.
(38) “Member” has the meaning given that term in OAR 410-120-0000.
(39) “Mental Health Organization (MHO)” means a PHP that provides capitated behavioral services for clients.
(40) “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.
(41) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax

expenses.
(42) “Non-Participating Provider” means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.
(43) “Oregon Health Authority or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.
(44) “Other Non-Medical Services” means non-state plan, health related services, also referred to as “flexible services.” These services are provided in–lieu of traditional benefits and are intended to improve care delivery, member health, and lower costs. Services may effectively treat or prevent physical or behavioral healthcare conditions. Services are consistent with the member’s treatment plan as developed by the member’s primary care team and documented in the member’s medical record.
(45) “Participating Provider” means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.
(46) “Physician Care Organization (PCO)” means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.
(47) “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 PHP or CCO.
(48) “Prioritized List of Health Services” means the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.
(49) “Service Area” means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.
(50) “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 healthcare professional. This therapeutic strategy is designed in collaboration with the member, the member’s family, or the member representative and may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0010

RULE TITLE: Prepaid Health Plan Contract Procurement Screening and Selection Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules brings these rule into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) Basis and scope:

(a) The Oregon Health Authority (Authority) will use screening and selection procedures to procure managed care services pursuant to ORS 414.651. The Authority may award Qualified Managed Care Organizations (MCO) a contract as a prepaid health plan (PHP) for purposes of administering the Oregon Health Plan (OHP);

(b) The OHP is funded with federal Medicaid funds. The Authority will interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with PHPs. The Authority will seek prior federal approval of PHP contracts;

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

(A) The Request for Application (RFA) process described in sections (3) through (6) of this rule; or

(B) Any method described in the Department of Justice's (DOJ) Model Rules (chapter 137, division 047) for source selection and procurement process, except for bidding.

(2) In addition to the terms defined in OAR 410-141-0000, the following definitions for screening and selection procedures apply:

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

(b) Application — Documents submitted by an MCO that seeks qualification to be Awarded a contract. The applicant is the MCO submitting the Application;

(c) Award — As the context requires, the act or occurrence of the Authority's identification of a qualified MCO with which the Authority will enter into a contract;

(d) Closing — The date and time announced in an RFA as the deadline for submitting Applications;

(e) MCO — A corporation, governmental agency, public corporation or other legal entity that operates as a managed health, dental, chemical dependency, physician care, or mental health organization;

(f) Managed care services— Capitated services provided by a PHP pursuant to ORS 414.651;

(g) Offer — A response to an RFA, including all required responses and assurances, and the Certification of Application;

(h) Request for applications (RFA) — All documents used by the Authority for soliciting applications for qualification in a specific RFA issued by the Authority, for one or more categories of contracts, one or more service areas or such other objective as the Authority may determine is appropriate for solicitation of managed care services.

(3) RFA process:

(a) The Authority will provide public notice of every RFA on its Web site. The RFA will indicate how prospective applicants will be made aware of addenda by posting notice of the RFA on the electronic system for notifying the public of the Authority procurement opportunities, or at the option of the requestor, mailing notice of the availability of the RFA to persons that have expressed interest in the Authority procurement of managed care services;

(b) The RFA process begins with a public notice of the RFA, which will be communicated with the electronic notification system used by the Authority to notify the public of procurement opportunities. A public notice of a RFA shall identify the qualification requirements for the category of contract (e.g., FCHP, DCO, etc.), the designated service area(s) where managed care services are requested or other objective that the Authority determines appropriate for solicitation of managed care services, and a sample contract;

(c) The Authority will provide notice of any RFA Addenda in a manner intended to foster competition and to make prospective applicants aware of the addenda. The RFA will specify how the Authority will provide notice of addenda;

(d) If the RFA so specifies, potential applicants must submit a letter of intent to the Authority within the time period

specified in the RFA. The letter of intent does not commit any potential applicant to apply, however, if required, the Authority will not consider applications from applicants who do not submit a timely letter of intent;
(e) Submitting the application — the Authority will only consider applications that are submitted in the manner described in the RFA. Applicants must:
(A) Identify electronic application submissions as defined in the RFA. The Authority is not responsible for any failure attributable to the transmission or receipt of electronic or facsimile applications, including but not limited to receipt of garbled or incomplete documents, delay in transmission or receipt of documents, or security and confidentiality of data;
(B) Submit applications, when sent by mail, in a sealed envelope that is marked appropriately;
(C) Ensure the Authority receives their applications at the required delivery point prior to the closing date, listed in the RFA. the Authority will not accept late applications.
(f) The application must be completed as described in the RFA. To avoid duplication and burden, the Authority may permit a current contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the new contract or the new service area or capacity or other Authority objective that is the subject of the RFA;
(g) The Authority will enter into or renew a contract only if it determines that the action would be within the scope of the RFA and consistent with the effective administration of the OHP, including but not limited to:
(A) The capacity of any existing PHP(s) in the service area compared to the capacity of an additional PHP for the number of potential enrollees in the service area;
(B) The potential opportunity for clients to have a choice of more than one PHP.
(h) Disclosure of application contents and release of information:
(A) Application information, including the letter of intent, shall not be disclosed to any applicant (or other person) until the completion of the RFA process. The RFA process shall be considered complete when a contract has been awarded. No information will be given to any applicant (or other person) relative to their standing with other applicants during the RFA process;
(B) Application information shall be subject to disclosure upon the award date, with the exception of information that has been clearly identified and labeled “Confidential” under ORS 192.501–192.502, insofar as the Authority determines it meets the requirements for an exemption from disclosure;
(C) Any requestor shall be able to obtain copies of non-exempt information after the RFA process has been completed. The requestor shall be responsible for the time and material expense associated with the request. This fee includes the copying of the document(s) and the staff time (and agency attorney time, if requested by the Authority) associated with performing the task, in accordance with ORS 192.440(3). The Authority may require prepayment of estimated charges before acting on a request:
(i) Protests must be submitted, in writing, to the Authority prior to the protest date specified in the RFA. The protest shall state the reasons for the protest or request and any proposed changes to the RFA provisions, specifications or contract terms and conditions that the prospective applicant believes will remedy the conditions upon which the protest is based. Protests and judicial review of the RFA shall be handled using the process set forth in OAR 137-047-0730;
(j) The Authority is not obligated to enter into a contract with any applicant, and further, has no financial obligation to any applicant.
(4) Application for qualification:
(a) An MCO seeking qualification as a PHP must meet the requirements and provide the assurances specified in the RFA. The Authority determines whether the MCO qualifies based on the application and any additional information and investigation that the Authority may require;
(b) The Authority determines an MCO is qualified when the MCO meets the requirements of the RFA, including written assurances, satisfactory to the Authority, that the MCO:
(A) Provides or will provide the services described in the contract;
(B) Provides or will provide the health services described in the contract in the manner described in the contract;

(C) Is organized and operated, and will continue to be organized and operated, in the manner required by the contract and described in the application;
(D) Under arrangements that safeguard the confidentiality of patient information and records, will provide to the Authority, CMS, the Office of Inspector General, the Oregon Secretary of State, and the Oregon Medicaid Fraud Unit of the DOJ, or any of their duly authorized representatives, for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the MCO relating to its operation as a PHP and to any facilities that it operates; and
(E) Will continue to comply with any other assurances it has given the Authority.
(c) The Authority may determine that an MCO is potentially qualified if within a specified period of time the MCO is reasonably susceptible of being made qualified. The Authority is not obligated to determine whether an applicant is potentially qualified if, in its discretion, the Authority determines that sufficient qualified applicants are available to obtain the Authority objectives under the RFA. The Authority determines that an MCO is potentially qualified if:
(A) The Authority finds that the MCO is reasonably susceptible to meeting the operational and solvency requirements of the application within a specified period of time; and
(B) The MCO enters into discussions with the Authority about areas of qualification that must be met before the MCO is operationally and financially qualified. The Authority will determine the date and required documentation and written assurances required from the MCO;
(C) If the Authority determines that a potentially qualified applicant cannot become a qualified MCO within the time announced in the RFA for contract award, the Authority may:
(i) Offer the contract at a future date when the applicant demonstrates, to the Authority's satisfaction, that the applicant is a qualified MCO within the scope of the advertised RFA; or
(ii) Inform the applicant that it is not qualified for contract Award.
(5) Evaluation and determination procedures:
(a) The Authority evaluates an application for qualification on the basis of information contained in the RFA, the application and any additional information that the Authority obtains. Evaluation of the application will be based on the criteria in the RFA;
(b) The Authority will notify each MCO that applies for qualification of its qualification status;
(c) Review of the Authority's qualification decisions shall be as set forth in ORS 279B.425;
(d) The Authority may enter into negotiation with qualified or potentially qualified applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity and the number of potential enrollees within the service area. The Authority may determine that it will limit contract award(s) to fewer than the number of qualified or potentially qualified applicants, to achieve the objectives in the RFA.
(6) Contract award conditions:
(a) The applicant's submission of the application with the executed Certification of Application is the MCO's offer to enter into a contract. The offer is a "Firm Offer," i.e., the offer shall be held open by the applicant for the Authority's acceptance 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;
(b) No Contingent offers. Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an MCO shall not make its offer contingent upon the Authority's acceptance of any terms or conditions other than those contained in the RFA;
(c) By timely signing and submitting the application and certification of application, the applicant acknowledges that it has read and understands the terms and conditions contained in the RFA and that it accepts and agrees to be bound by the terms and conditions of the RFA;
(d) The Authority may award multiple contracts in accordance with the criteria set forth in the RFA. The Authority may make a single award or limited number of awards rather than multiple awards to all qualified or potentially qualified applicants, in order to meet the Authority's needs including but not limited to adequate capacity for the potential enrollees in the service area;

(e) An applicant who claims to have been adversely affected or aggrieved by Authority contract award or intent to award a contract must file a written protest with the Authority issuing office within seven (7) calendar days after receiving the notice of award. Protests and judicial review of contract award shall be handled using the procedures set forth in OAR 137-047-9740.
(7) Applicability of DOJ Model Rules: Except where inconsistent with the preceding sections of this rule, the Authority will use the following DOJ Model Rules to govern solicitations for managed care services:
(a) OAR 137-046 — General Provisions Related to Public contracting: 137-046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;
(b) OAR 137-047 — Public Procurements for Goods or Services: 137-047-0100, 137-047-0260 through 137-047-0330, 137-047-0400 through 137-047-0800.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0160

RULE TITLE: Oregon Health Plan Prepaid Health Plan (PHP) Coordination and Continuity of Care

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) PHPs shall have written policies, procedures, and monitoring systems that ensure the provision of Medical Case Management Services and delivery of primary care to and coordination of health care services for all members:

(a) PHPs are to coordinate and manage capitated services and non-capitated services and ensure that referrals made by the PHP's providers to other providers for covered services are noted in the appropriate Division member's clinical record;

(b) PHPs shall ensure members receiving Exceptional Needs Care Coordination (ENCC) services for the aged, blind, or disabled who have complex medical needs as described in 410-141-0405 are noted in the appropriate Division member’s record. ENCC is a service available through Fully Capitated Health Plans (FCHPs) or Physician Care Organizations (PCOs) that is separate from and in addition to medical case management services;

(c) These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a practitioner or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with OAR 410-141-0120;

(d) FCHPs and PCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. FCHPs and PCOs shall document all monitoring and corrective action activities:

(A) PHPs shall develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by contracts/agreements with the Division). PHPs shall ensure that access to and quality of care provided in all referral settings is monitored. Referral services and services received in alternative care settings shall be reflected in the member's clinical record. PHPs shall establish and follow written procedures for participating and non-participating providers in the PHP's referral system. Procedures shall include the maintenance of records within the referral system sufficient to document the flow of referral requests, approvals, and denials in the system;

(B) The member shall obtain all covered services either directly or upon referral from the PHP responsible for the service from the date of enrollment through the date of disenrollment, except when the member is enrolled in a Medicare HMO or Medicare Advantage FCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or Medicare Advantage and MHOs have significant and shared responsibility for prepaid services and shall coordinate benefits for the member to ensure that the member receives all medically appropriate services covered under respective capitation payments;

(ii) If the member is enrolled in a FCHP or PCO with a Medicare HMO component or Medicare Advantage, then Medicare covered mental health services shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO, respectively. Mental health services that are not covered by the FCHP or PCO but are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(C) PHPs shall have written procedures for referrals that ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the member's clinical record;

(D) PHPs shall designate a staff member who is responsible for the arrangement, coordination, and monitoring of the PHP's referral system;

(E) PHPs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional;

(F) PHPs shall have written procedures that ensure relevant medical, mental health, and dental information is obtained from referral providers including telephone referrals. These procedures shall include:

(i) Review of information by the referring provider;
(ii) Entry of information into the member's clinical record;
(iii) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral providers, reviewed by the referring practitioner, and entered into the clinical record.
(G) PHPs shall have written procedures to orient and train their staff, participating practitioners and their staff, the staff in alternative care settings, and staff in urgent and emergency care facilities in the appropriate use of the PHP's referral, alternative care, and urgent and emergency care systems. Procedures and education shall ensure use of appropriate settings of care;
(H) PHPs shall have written procedures that ensure an appropriate staff person responds to calls from other providers requesting approval to provide care to members who have not been referred to them by the PHP. If the person responding to the call is not a health care professional, the PHP shall have established written protocols that clearly describe when a health care professional needs to respond to the call. These procedures and protocols shall be reviewed by the PHP for appropriateness. The procedures shall address notification of acceptance or denial and entry of information into the PCP's clinical record;
(I) FCHPs and PCOs shall have written policies and procedures to ensure information on all emergency department visits is entered into the member's appropriate PCP's clinical record. FCHPs and PCOs shall communicate this policy and procedure to providers, monitor providers' compliance with this policy and procedure, and take corrective action necessary to ensure compliance;
(J) If a member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:
(i) A notation is made in the member's appropriate PCP's clinical record of the reason, date, and expected duration of the hospitalization;
(ii) Upon discharge, a notation is made in the member's appropriate PCP's clinical record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and
(iii) Pertinent reports from the hospitalization are entered in the member's appropriate PCP's clinical record. Such reports shall include, as applicable, the reports of consulting practitioners' physical history, psycho-social history, list of medications and dosages, progress notes, and discharge summary.
(2) For members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure the member has timely and appropriate access to covered services and to ensure coordination of care provided by the PHP and care provided by the facility or home. PHPs shall make provisions for a PCP or the facility's "house doctor or dentist" to provide care to members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.
(3) For members living in residential facilities or homes providing ongoing care, FCHPs and PCOs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs and PCOs shall provide emergency prescriptions on a 24-hour basis.
(4) For members who are discharged to post hospital extended care, the FCHP shall notify the appropriate Authority office at the time of admission to the skilled nursing facility (SNF) and begin appropriate discharge planning. The FCHP is not responsible for the post hospital extended care benefit unless the member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the member no later than two full working days prior to discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the appropriate DHS office shall be notified at the time the FCHP learns of the admission. The FCHP shall initiate appropriate discharge planning at the time of the notification to the Authority office.
(5) PHPs shall coordinate the services the PHP furnishes to members with the services the member receives from any other PHP (FCHP, PCO, DCO, CDO, or MHO) in accordance with OAR 410-141-0120(6). PHPs shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.
(6) When a member's care is being transferred from one PHP to another or for clients transferring from fee-for-service

to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the client into the care of a PHP participating provider.
(7) PHPs shall make attempts to contact targeted Division populations by mail, telephone, in person, or through the Authority within the first three months of enrollment to assess medical, mental health, or dental needs appropriate to the PHP. The PHP shall, after reviewing the assessment, refer the member to his PCP or other resources as indicated by the assessment. Targeted populations shall be determined by the PHP and approved by the Division.
(8) MHOs shall establish working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area for the purposes of maintaining a comprehensive and coordinated mental health delivery system and to help ensure member access to mental health services that are not provided under the capitation payment.
(9) MHOs shall ensure that members receiving services from extended or long term psychiatric care programs (e.g., secure residential facilities, PASSAGES projects, state hospital) will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.
(10) MHOs shall coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis.
(11) MHOs shall use a multi-disciplinary team service planning and case management approach for members requiring services from more than one public agency. This approach shall help avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive treatment setting (e.g., clinic, home, school, community).
(12) MHOs shall consult with and provide technical assistance to FCHPs and PCOs to help assure that mental health conditions of members are identified early so that intervention and prevention strategies can begin as soon as possible.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0260

RULE TITLE: Managed Care Prepaid Health Plan Complaint or Grievance and Appeal Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) Definitions:

(a) Action — In the case of a PHP:

(A) The denial or limited authorization of a requested service, including the type or level of service;

(B) The reduction, suspension or termination of a previously authorized service;

(C) The denial in whole or in part, of payment for a service;

(D) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (Division);

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

(F) For a Division member in a single PHP service area, the denial of a request to obtain services outside of the PHP's participating provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(b) Appeal — A request by a Division member or representative for review of an "action" as defined in this section;

(c) Complaint — A Division member's or Division member's representative's expression of dissatisfaction to a PHP or to a practitioner about any matter other than an action, as "action" is defined in this section;

(d) Grievance System — The overall system that includes a complaint process, an appeals process and access to the Division's administrative hearing process.

(2) The purpose of OAR 410-141-0260 through 410-141-0266 is to describe the requirements for the overall grievance system. These rules will apply to all PHPs as defined in 410-141-0000.

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

(4) Information provided to the Division member shall include at least:

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

(b) Assurance in all written, oral, and posted material of Division member confidentiality in the complaint and appeal processes.

(5) A Division member or a Division member's representative may file a complaint and a PHP level appeal orally or in writing, and may request a Division administrative hearing.

(6) PHPs shall keep all information concerning a Division member's complaint or appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

(7) Consistent with confidentiality requirements, the PHP's staff person who is designated to receive complaints or appeals, shall begin to obtain documentation of the facts concerning the complaint or appeal upon receipt of the complaint or appeal.

(8) PHPs shall afford Division members full use of the grievance system procedures. If the Division member decides to pursue a remedy through the Division's administrative hearing process, the PHP will cooperate by providing relevant information required for the hearing process.

(9) A request for a Division administrative hearing made to the Division outside of the PHP's appeal procedures, or without previous use of the PHP's appeal procedures shall be reviewed by the PHP through the PHP's appeal process upon notification by the Division as provided for in OAR 410-141-0264.

(10) Under no circumstances may a PHP discourage a Division member or a Division member's representative from using the Division's administrative hearing process.

(11) Neither implementation of a Division hearing decision nor a Division member's request for a hearing may be a basis

for a request by the PHP for a Division member's disenrollment.
(12) PHPs shall make available a supply of blank complaint forms (OMAP 3001) in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals. PHPs shall make available a supply of blank Administrative Hearing Request forms (DHS 443) and the Notice of Hearing Rights forms (DMAP 3030). PHPs shall develop an appeal form and shall make the appeal forms, along with the DHS 443 and DMAP 3030 forms, available in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals.
(13) The PHP must provide information about the grievance system to all participating providers and subcontractors at the time they enter into a contract.
(14) The PHP must maintain logs that are in compliance with OAR 410-141-0266 to document complaints and appeals received by the PHP, and the State must review the information as part of the State quality strategy.
[ED. NOTE: Forms referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0261

RULE TITLE: PHP Complaint Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

The Division may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) A grievance (see definition) procedure applies only to those situations in which the Division member (see definition) or their respresentative (see definition) expresses concern or dissatisfaction about any matter other than an "action." PHPs shall have written procedures to acknowledge the receipt, disposition and documentation of each grievance from Division members. The PHP's written procedures for handling grievances, shall, at a minimum:

(a) Address how the PHP will accept, process and respond to each grievance from a Division member or their respresentative, including:

(A) Acknowledgment to the Division member or respresentative of receipt of each grievance;

(B) Ensuring that Division members who indicate dissatisfaction or concern are informed of their right to file a grievance and how to do so;

(C) Ensuring that each grievance is transmitted timely to staff having authority to act upon it;

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

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

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

(ii) Who are health care professionals who have appropriate clinical expertise in treating the Division member's condition or disease if the grievance concerns denial of expedited resolution of an appeal or if the grievance involves clinical issues:

(b) Describe how the PHP informs Division members, both orally and in writing, about the PHP's grievance procedures;

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

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

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

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

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

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

release of information shall be included in the PHP's written process.
(4) The PHPs procedures shall provide for the disposition of grievances within the following timeframes:
(a) The PHP must resolve each grievance, and provide notice of the disposition, as expeditiously as the Division member's health condition requires, within the timeframes established in this rule;
(b) For standard disposition of grievances and notice to the affected parties, within 5 working days from the date of the PHP's receipt of the grievance, the PHP must either:
(A) Make a decision on the grievance and notify the Division member; or
(B) Notify the Division member in writing that a delay in the PHP's decision of up to 30 calendar days from the date the grievance was received by the PHP is necessary to resolve the grievance. The PHP shall specify the reasons the additional time is necessary.
(5) The PHP's decision about the disposition of a grievance shall be communicated to the Division member orally or in writing within the timeframes specified in (4) of this rule:
(a) An oral decision about a grievance shall address each aspect of the Division member's grievance and explain the reason for the PHP's decision;
(b) A written decision must be provided if the grievance was received in writing. The written decision on the grievance shall review each element of the Division member's grievance and address each of those concerns specifically, including the reasons for the PHP's decision.
(6) All grievances made to the PHP's staff person designated to receive grievances shall be entered into a log and addressed in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.
(7) All grievances that the Division member chooses to resolve through another process, and that the PHP is notified of, shall be noted in the grievance log.
(8) Division members who are dissatisfied with the disposition of a grievance may present their grievance to the Governors Advocacy Office.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0262

RULE TITLE: Prepaid Health Plan Appeal Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) A Division of Medical Assistance Programs (Division) Member or their representative that disagrees with a Notice of Action may file a Prepaid Health Plan (PHP) level appeal or request a Division administrative hearing. Division members may not be required to go through a PHP level appeal in order to request a Division administrative hearing.

(2) The PHP must have a system in place for Division member which includes an appeal process when a Division member has requested a Division administrative hearing. For purposes of this rule, an appeal includes a request to the PHP for review of an Action upon notification from the Division.

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

(4) If the Division member initiates an appeal directly with the PHP, it shall be documented in writing by the PHP and handled as an appeal consistent with this rule. The Division member or Division member's representative may file an appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed appeal.

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

(a) Give Division members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal or administrative hearings request. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Tele Typewriter (TTY)/ Telecommunications Devices for the Deaf (TTD) and interpreter capacity;

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

(c) Ensuring that Division members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an appeal and an administrative hearing request and how to do so;

(d) Ensuring that each appeal is transmitted timely to staff having authority to act on it;

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

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

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

(B) Who are health care professionals who have the appropriate clinical expertise in treating the Division member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues:

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

(6) The PHP shall assure Division members that appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the appeal have a right to use this information for purposes of resolving the appeal and for purposes of maintaining the log required

in OAR 410-141-0266 and for health oversight purposes by Division, without a signed release from the Division member. The administrative hearing regarding the appeal without a signed release from the Division member, pursuant to 410-120-1360(4);
(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the appeal to other individuals. Before any information related to the appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the appeal file.
(7) The process for appeals must:
(a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the Division member or Division member's representative requests expedited resolution;
(b) Provide the Division member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the Division member or the Division member's representative of the limited time available in the case of an expedited resolution);
(c) Provide the Division member and/or the Division member's representative an opportunity, before and during the appeals process, to examine the Division member's file, including medical records and any other documents or records to be considered during the appeals process; and
(d) Include as parties to the appeal the Division member, the Division member's representative, or the legal representative of a deceased Division member's estate.
(8) The PHP must resolve each appeal and provide a client notice of the appeal resolution as expeditiously as the Division member's health condition requires and within the time frames in this section:
(a) For the standard resolution of appeals and client notices to the Division member or Division member's representative, the PHP shall resolve the appeal and provide a client notice no later than 16 calendar days from the day the PHP receives the appeal.
(b) When the PHP has granted a request for expedited resolution of an appeal, the PHP shall resolve the appeal and provide a client notice no later than 3 working days after the PHP receives the appeal. This timeframe may be extended pursuant to subsection (c) of this section;
(c) In accordance with 42 CFR 438.408, the PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:
(A) The Division member or Division members representative requests the extension; or
(B) The PHP shows (to the satisfaction of the Division's Hearings Unit upon its request) that there is need for additional information and how the delay is in the Division member's interest;
(d) If the PHP extends the timeframes, it must, for any extension not requested by the Division member, give the Division member or Division member's representative a written notice of the reason for the delay.
(9) For all appeals, the PHP must provide written Notice of Appeal Resolution to the Division member or their representative. If the PHP knows that there is a representative, the PHP must send a copy of the Notice to the representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.
(10) The written Notice of Appeal Resolution must be on a Division approved form and include the following:
(a) The results of the resolution process and the date it was completed; and
(b) For appeals not resolved wholly in favor of the Division member, the notice must also include the following information:
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
(B) Unless the appeal was referred to the PHP from the Division as part of an administrative hearings process, the right to request a Division Administrative Hearing, and how to do so, which includes attaching the appropriate forms as outlined in 410-141-0263;

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and
(D) That the Division member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.
(11) Unless the appeal was referred to the PHP as part of an administrative hearing process, a Division member may request a Division administrative hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution. The parties to the Division administrative hearing include the PHP as well as the Division member and/or Division member's representative, or the Representative of the deceased Division member's estate.
(12) Each PHP shall establish and maintain an expedited review process for appeals, consistent with OAR 410-141-0265.
(13) Each PHP shall maintain records of appeals, enter appeals and their resolution into a log, and address the appeals in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.
(14) Continuation of benefits pending appeal:
(a) As used in this section, "timely" filing means filing on or before the later of the following:
(A) Within 10 calendar days of the PHP mailing the Notice of Action; or
(B) The intended effective date of the PHP's proposed Action:
(b) The PHP must continue the Division member's benefits if:
(A) The Division member or Division member's representative files the appeal or administrative hearing request timely;
(B) The appeal or administrative hearing request involves the termination, suspension, or reduction of a previously authorized course of treatment;
(C) The services were ordered by an authorized provider;
(D) The original period covered by the original authorization has not expired; and
(E) The Division member or representative requests extension of benefits:
(c) Continuation of benefits pending administrative hearing — If, at the Division member's request, the PHP continues or reinstates the Division member's benefits while the appeal or administrative hearing is pending , the benefits must be continued pending administrative hearing pursuant to OAR 410-141-0264.
(15) If the final resolution of the appeal or administrative hearing is adverse to the Division member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the Division member while the appeal or administrative hearing was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).
(16) If the PHP or a Division administrative hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the Division member's health condition requires.
(17) If the PHP or the Division administrative hearing decision reverses a decision to deny authorization of services, and the Division member received the disputed services while the appeal was pending, the PHP or the Division must pay for the services in accordance with the Division policy and regulations.
(18) If the appeal was referred to the PHP from the Division as part of an administrative hearing process, the PHP must immediately (within two business days) transmit the Notice of Appeal Resolution and the complete record of the appeal to the Division Hearings Unit.
(19) If the appeal was made directly by the Division member or Representative, and if the Notice of Appeal Resolution was not favorable to the Division member, the PHP must: Retain a complete record of the appeal for not less than 45 days so that, if an administrative hearing is requested, the record can be submitted to the Division's Hearings Unit within two business days of the Division's request.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0263

RULE TITLE: Notice of Action by a Prepaid Health Plan

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) When a Prepaid Health Plan (PHP) or authorized practitioner (see definition) acting on behalf of the PHP takes or intends to take any "action," including but not limited to denials or limiting prior authorizations of a requested service in an amount, duration or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other action, the PHP or authorized practitioner acting on behalf of the PHP shall mail a written client (see definition) Notice of Action (NOA) in accordance with section (2) of this rule to the Division member (see definition) within the timeframes specified in subsection (3) of this rule.

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

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

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) The Division member's name and ID number;

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

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

(G) Effective date of the action, if different from the date of the NOA;

(H) Whether the PHP considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(b) The action the PHP or its participating provider (see definition) has taken or intends to take;

(c) Reasons for the action with enough specificity to clearly explain the actual reason for the denial, including but not limited to the following reasons:

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

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

(C) The person was not a Division member at the time of the service or is not a Division member at the time of a requested service; and

(D) The provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan rules);

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

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

(f) The Division member's right to request a Division administrative hearing and how to exercise that right. A copy of the following forms must be attached to the Notice of Action:

(A) Hearing Request form (DHS 443) and the Notice of Hearing Rights (DMAP 3030), or

(B) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form DMAP 3302 or

approved facsimile.
(g) The circumstances under which expedited appeal resolution is available and how to request it;
(h) The Division member's right to have benefits continue pending resolution of the appeal, how to request that benefit be continued and the circumstances under which the Division member may be required to pay the costs of these services; and
(i) The telephone number to contact the PHP for additional information.
(3) The PHP or practitioner acting on behalf of the PHP must mail the Notice of Action within the following time frames:
(a) For termination, suspension or reduction of previously authorized OHP covered services (see definition), the following time frames apply:
(A) The notice must be mailed at least ten calendar days before the date of action, except as permitted under subsections (B) or (C) of this section;
(B) The PHP or authorized practitioner acting on behalf of the PHP may mail a notice not later than the date of action if:
(i) The PHP or practitioner receives a clear written statement signed by the Division member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;
(ii) The Division member has been admitted to an institution where he or she is ineligible for covered services from the PHP;
(iii) The Division member's whereabouts are unknown and the post office returns PHP or practitioner's mail directed to him or her indicating no forwarding address;
(iv) The PHP establishes the fact that another state, territory, or commonwealth has accepted the Division member for Medicaid services;
(v) A change in the level of medical or dental care is prescribed by the Division member's PCP or PCD; or
(vi) The date of action will occur in less than ten calendar days in accordance with 42 CFR 483.12(a)(5)(ii) related to discharges or transfers and long-term care facilities:
(C) The PHP may shorten the period of advance notice to five calendar days before the date of the action if the PHP has facts indicating that an action should be taken because of probable fraud by the Division member. Whenever possible, these facts should be verified through secondary sources:
(b) For denial of payment at the time of any action affecting the claim;
(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the Division member's health condition requires and within 14 calendar days following receipt of the request for service, except that:
(A) The PHP may have a possible extension of up to 14 additional calendar days if the Division member or the provider requests the extension or if the PHP justifies (to the Division upon request) a need for additional information and how the extension is in the Division member's interest;
(B) If the PHP extends the timeframe in accordance with subsection (A) of this section, it shall give the Division member written notice of the reason for the decision to extend the timeframe and inform the Division member of their right to file a grievance if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the Division member's health condition requires and no later than the date the extension expires;
(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section (which constitutes a denial and is thus an adverse action) on the date that the timeframes expire;
(e) For expedited prior authorizations within the timeframes specified in OAR 410-141-0265.
[Publications: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0264

RULE TITLE: Administrative Hearings

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) An individual who is or was a Division member at the time of the notice of action is entitled to a contested case hearing if a Prepaid Health Plan (PHP) has denied requested services, payment of a claim, or terminates, discontinues or reduces a course of treatment, or any other action.

(a) If a member receives an adverse notice of action, the member may file a request for a contested case hearing. :

(b) If a member receives an adverse notice of appeal resolution from the PHP, the member may request a contested case hearing based on the notice of appeal resolution.:

(c) Contested case hearings are governed by OAR 410-120-1860, 410-120-1865, and this rule.

(2) A written hearing request must be received by the Division not later than the 45th day following the date of the Notice of Action, or if the hearing request was initiated after an appeal, not later than the 45th day following the Notice of Appeal Resolution.

(3) Effective, February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in the division of rules in OAR 410 division 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Division hearing requests.

(4) 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 must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (4)(a) of this rule, delay caused by circumstances beyond the control of the member is not counted.

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits, no later than ten days following the date of the notice of appeal resolution;

(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 hearing.

(5) The Division representative shall review the hearing request, documentation related to the hearing issue, and computer records to determine whether the claimant or the individual for whom the request is being made is or was a Division member at the time the action was taken, and whether the hearing request was timely.

(6) PHPs shall immediately transmit to the Division any hearing request submitted on behalf of a member, including a copy of the notice of action and, if applicable, notice of appeal resolution.

(7) If the member files a request for hearing with the Division, the Division shall send a copy of the hearing request to the PHP.

(8) PHPs shall review a hearing request, which has not been previously received or reviewed as an appeal, using the PHP's appeal process as follows:

(a) The appeal shall be reviewed immediately and shall be resolved, if possible, within 16 calendar days, pursuant to OAR 410-141-0262;

(b) The PHP shall provide the member with a written notice of appeal resolution.
(9) When a member requests a hearing, the PHP shall cooperate with providing relevant information required for the hearing process to the Division, as well as the results of the review by the PHP of the appeal and the administrative hearing request, and any attempts at resolution by the PHP.
(10) Information about members used for administrative hearings is handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The Division shall safeguard the member's right to confidentiality of information used in the hearing as follows:
(a) The Division, the member and their representative, the PHP and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the hearing may use this information for purposes of resolving the hearing without a signed release from the member. The Division may also use this information, pursuant to OAR 410-120-1360(4), for health oversight purposes, and for other purposes authorized or required by law. The information may also be disclosed to the Office of Administrative Hearings and the Administrative Law Judge assigned to the hearing and to the Court of Appeals if the member seeks judicial review of the final order;
(b) Except as provided in subsection (a), the Division shall ask the member to authorize a release of information regarding the hearing to other individuals. Before any information related to the hearing is disclosed under this subsection, the Division must have an authorization for release of information documented in the hearing file.
(11) The hearings request and the notice of appeal resolution shall be referred to the Office of Administrative Hearings and the hearing will be scheduled.
(a) The parties to the hearing shall include the PHP, the member and his or her representative, or the representative of a deceased member's estate;
(b) The procedures applicable to the hearing shall be conducted consistent with OAR 410-120-1860 and 410-120-1865;
(c) A final order should be issued or the case otherwise resolved by the Division ordinarily within 90 calendar days from the earlier of the following:
(A) The date the member requested a PHP appeal, not including the number of days the member took to subsequently file a request for hearing or
(B) The date the member filed a request for contested case hearing.
(d) The final order is the final decision of the Division.
(12) If the hearing decision is adverse to the member, the PHP may recover the cost of the services furnished to the member while the hearing is pending, to the extent that they were furnished solely because of the requirements of this rule and in accordance with forth in 42 CFR 438.420.
(13) The PHP must promptly correct the action taken up to the limit of the original request or authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the member, or Division or the PHP decides in the member's favor before the hearing even if the member has lost eligibility after the date the action was taken:
(a) If the PHP, or a hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the hearing was pending, the PHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires;
(b) If the PHP, or the hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the hearing was pending, the PHP must pay for the services in accordance with Division policy and regulations in effect when the member requested the services.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0265

RULE TITLE: Request for Expedited Appeal or Expedited Administrative Hearing

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) Each PHP shall establish and maintain an expedited review process for appeals, when the PHP determines (upon request from the Division of Medical Assistance Programs (Division) member) or the provider indicates (in making the request on a Division member's behalf or supporting the DMAP member's request) that taking the time for a standard resolution could seriously jeopardize the Division member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Division member's appeal.

(3) If the PHP provides an expedited appeal, but denies the services or items requested in the expedited appeal, the PHP shall inform the Division member of the right to request an expedited Administrative Hearing and send the member a Division approved Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-0263 with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on appeal, it must:

(a) Transfer the appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A Division member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the Division member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to the Division's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. The Division's Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether the Division member is entitled to an expedited Administrative Hearing.

(7) If the Division's Medical Director denies a request for expedited Administrative Hearing, the Division must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

[ED. NOTE: Forms referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0266

RULE TITLE: PHP's Responsibility for Documentation and Quality Improvement Review of the Grievance System

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) The PHP's documentation shall include, at minimum, a log of all oral and written complaints and appeals received by the PHP. The log shall identify the Division member and the following additional information:

(a) For complaints, the date of the complaint, the nature of the complaint, the disposition and date of disposition of the complaint;

(b) For appeals, the date of the Notice of Action, the date of the appeal, the nature of the appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the appeal. If an administrative hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the administrative hearing.

(2) The PHP shall also maintain a record for each of the complaints and appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the Division member. The PHPs shall retain documentation of complaints and appeals for seven years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the grievance system, including all complaints and appeals received by the PHP. The analysis of the grievance system shall be forwarded to the quality improvement committee as necessary to comply with the quality improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of complaints and appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of complaints and appeals, and compliance with Oregon Health Plan rules.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0280

RULE TITLE: Managed Care Prepaid Health Plan Potential Member Informational Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

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

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

(b) "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 MCO or CCO;

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

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

(B) 1,000 of the MCO's members;

(d) "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.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-0270, Prepaid Health Plan Marketing Requirements for Potential Members.

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

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

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

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

(b) Improving coordination of care;

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

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

(6) MCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) MCOs shall develop informational materials for potential members.

(8) MCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCO shall make available to potential members, upon request, information on participating providers.

(9) MCO provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(10) MCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. 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.

(11) MCO's shall honor requests made by other sources such as potential members, potential family members, or

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:
(a) MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);
(b) MCOs shall ensure that all MCO staff who have contact with potential members are fully informed of MCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free certified interpreter services, and which participating providers' offices have bilingual capacity and which are accepting new members.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.725

REPEAL: 410-141-0300

RULE TITLE: Managed Care Organization (MCO) Member Education and Information Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

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

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

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

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

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

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

(B) 1, 000 of the MCO's members;

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

(a) Is intended solely for members; and

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

(3) MCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications shall be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health–related events. MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate formats.

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

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

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

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

(b) Improving coordination of care;

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

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

(7) MCOs shall have a mechanism to help members understand the requirements and benefits of the MCO plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) MCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. Member education shall:

(a) Include information about the Exceptional Needs Care Coordination (ENCC) or case management services to

members who are aged, blind, disabled, or have complex medical needs consistent with OAR 410-141-0405 and how to access that system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;
(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that certified health care interpreter services at provider offices are free to MCO members as stated in 42 CFR 438.10 (4).
(9) Within 14 calendar days or a reasonable timeframe of an MCO receiving notice of a member's enrollment, MCOs shall mail a welcome packet to new members and to members returning to the MCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory.
(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.
(11) For those who are existing members, an MCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCOs shall send hard copies upon request.
(12) MCOs shall facilitate materials as follows:
(a) Translate the following written materials into the prevalent non-English languages served by the MCO:
(A) Welcome packets that include welcome letters and member handbooks; and
(B) Notices of medical benefit changes;
(b) Include alternate format statement inserts with:
(A) Communications regarding member enrollment; and
(B) Notice of Action to deny, reduce, or stop a benefit;
(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCO;
(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;
(e) Notify enrollees:
(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and
(B) How to access those services.
(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large (18 point) type, and braille.
(13) An MCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:
(a) Revision date;
(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille;
(c) MCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;
(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and the MCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;
(f) What participating or non-participating provider services the member may self-refer;
(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;
(h) Explanation of Exceptional Needs Care Coordination (ENCC) services and how members with special health care needs who are aged, blind, or disabled, or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency can access ENCC services;
(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;
(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;
(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;
(L) Information on contracted hospitals in the member's service area;
(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;
(n) Information on the MCO's grievance and appeals processes and the Division's contested case hearing procedures, including:
(A) Information about assistance in filling out forms and completing the grievance process available from the MCO to the member as outlined in OAR 410-141-3260;
(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3260;
(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;
(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;
(q) Information about when providers may bill clients for services and what to do if they receive a bill; including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;
(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;
(s) Information on advance directive policies including:
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
(B) The MCO'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 MCO uses provider incentives to reduce cost by limiting services;
(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;
(v) How and when members are to obtain ambulance services;
(w) Resources for help with transportation to appointments with providers;
(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;
(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;
(z) The MCO's confidentiality policy;

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the MCO's contract, including any cost sharing;
(bb) When and how members can voluntarily and involuntarily disenroll from MCOs and change MCOs;
(cc) MCOs 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 MCO's internal changes. If changes affect the member's ability to use services or benefits, the MCO shall offer the updated member handbook to all members;
(dd) The "Oregon Health Plan Client Handbook" is in addition to the MCO's member handbook, and an MCO shall not use it to substitute for any component of the MCO's member handbook.
(14) Member health education shall include:
(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCO providers or other individuals or programs approved by the MCO may provide health education. MCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;
(b) MCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;
(c) Explanation of ENCC services and how to access ENCC services through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;
(d) 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;
(e) MCOs 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 MCO's participating providers. The MCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the MCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.
(15) Informational materials that MCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:
(a) MCOs shall provide free certified health care interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care;
(b) MCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. MCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;
(c) MCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language;
(d) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.
(16) MCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCO, members, and providers.

[Publications: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

AMEND: 410-141-3000

RULE TITLE: Managed Care Entity Definitions

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Updated MCE definitions.

RULE TEXT:

(1) The Oregon Health Authority adopts and incorporates by reference the definitions below for use by the Managed Care Entities in the following administrative rules and applies them to Health System Transformation:

(a) OARs 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;

(b) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and

(c) OAR 410-141-3000.

(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. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

(3) "Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service. See OAR 410-141-3240 for a member enrolled in an MCE.

(4) "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.

(5) "Applicant" means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services.

(6) "Application" means an entity's written response to a Request for Application (RFA).

(7) "Auxiliary Aids and Services" are to be made available to members as defined in CMS Section 1557 of the ACA.

(8) "Award Date" means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts.

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

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

(11) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.

(12) "Certification" means the Authority's determination that an entity meets the criteria in OAR 410-141-3015 and the standards set forth in the RFA for being a CCO through initial certification or recertification.

(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) "Cold Call Marketing" means an MCE's unsolicited personal contact, including texting and email, with a potential member for the purpose of marketing.

(16) "Community Advisory Council" 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) "Community Standard" means typical expectations for access to the health care delivery system in the member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, the

Division requires that the health care delivery system available to Division members in MCEs take into consideration the community standard and be adequate to meet the needs of the Division's enrollment.
(18) "Contract" means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.
(19) "Converting MCO" means a CCO that:
(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;
(b) Was formed by one or more MCEs that contracted with the Authority as of July 1, 2011.
(20) "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.
(21) "Coordinated Care Services" mean an MCE's fully integrated physical health, behavioral health services, and oral health services.
(22) "Corrective Action or Corrective Action Plan" means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.
(23) "Dental Care Organization (DCO)" means an MCE that provides and coordinates dental services as capitated services under OHP.
(24) "Dental Case Management Services" means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.
(25) "DCBS Reporting CCO" means a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.
(26) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection agency.
(27) "Disenrollment" means the act of removing a member from enrollment with an MCE.
(28) "Exceptional Needs Care Coordination (ENCC)" means for PHPs a specialized case management service provided to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(29) "Enrollment" means the assignment of a member to an MCE for management and receipt of health services.
(30) "Entity" means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization.
(31) "Free-Standing Mental Health Organization (MHO)" means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.
(32) "Fully-Capitated Health Plan (FCHP)" means an MCE that contracts with the Authority to provide capitated health services including inpatient hospitalization.
(33) "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.
(34) "Grievance System" means the overall system that includes:
(a) Grievances to an MCE on matters other than actions;
(b) Appeals to an MCE on actions; and
(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or statute.
(35) "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.

(36) “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. Health-related services include flexible services and community benefit initiatives. Flexible services are cost-effective services offered to an individual member to supplement covered benefits. 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) The goals of health-related services 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 billable office visits and are often cost-effective services offered as an adjunct to covered benefits. Health-related services lack traditional billing or encounter codes, are not encounterable, and may not be reported for utilization purposes;
(b) To be considered a health-related service, a service must meet the requirements for:
(A) Activities that improve health care quality as defined in 45 CFR 158.150; or
(B) Expenditures related to Health Information Technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.
(37) “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.
(38) “Home CCO” means enrollment in a CCO in a given service area based upon a client’s most recent permanent residency, determined at the time of original eligibility or most current point of CCO enrollment prior to hospitalization.

(39) “Indian” means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12 and:
(a) Is a member of a federally recognized Indian tribe;
(b) Resides in an urban center and meets one or more of the four criteria;
(c) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside or who is a descendant in the first or second degree of any such member:
(A) Is an Eskimo or Aleut or other Alaska Native;
(B) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(C) Is determined to be an Indian under regulations issued by the Secretary:
(i) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(ii) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
(40) “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).
(41) “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.
(42) “Intensive Case Management (ICM)” means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall

be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(43) “Licensed Health Entity” means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.
(44) “Limited English Proficient (LEP)” means potential members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
(45) “Line Items” means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.
(46) “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 managed care organizations, prepaid health plans, and primary care case managers.
(47) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular PHP or CCO.
(48) “Medicaid-funded Long-term Care or Long-term Services and Supports” means all Medicaid funded services CMS defines as long-term services and supports that include both:
(a) “Long-term Care” means 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 Behavioral Health, including state psychiatric hospitals;
(b) “Long-term Services and Supports” means the Medicaid services and supports provided under a CMS approved waiver to assist individual’s needs and to avoid institutionalization as defined in OAR 411, chapter 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410 division 172 (Medicaid Behavioral Health).
(49) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.
(50) “Member” has the meaning given that term in OAR 410-120-0000.
(51) “Mental Health Organization (MHO)” means an MCE that provides capitated behavioral services for clients.
(52) “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.
(53) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.
(54) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.
(55) “Oregon Health Authority or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.
(56) “Participating Provider” means a provider that has a contractual relationship with an MCE and is on their panel of providers.
(57) “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 PHP or CCO.
(58) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:
(a) Five percent of the MCE’s total OHP enrollment; or
(b) One thousand of the MCE’s members.
(59) “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.

(60) "Request for Applications (RFA)" means the document used for soliciting applications for certification as 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.

(61) "Service Area" means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(62) "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 healthcare professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member representative.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3010

RULE TITLE: CCO Application, Certification, and Contracting Procedures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Movement of definitions out of 410-141-3010 into the managed care definition section.

RULE TEXT:

(1) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.

(2) The Authority shall use the following RFA processes for CCO certification and contracting:

(a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants will be 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 begins with a public notice that shall be communicated using the Authority's website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested, and a sample contract;

(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 will request information from applicants in order 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 submission of the application on its web portal in accordance with OAR 137-047-0330 Electronic Procurements. If electronic procurement is used, applications shall be accepted only from applicants who accept the terms and conditions for use of the Authority's web portal.

(3) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity or other purposes within the scope of the RFA.

(4) The Authority shall evaluate applications for certification on the basis of criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria:

(a) 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;

(b) The Authority shall notify each applicant that applies for certification of its certification status;

(c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.

(5) Review for certification:

(a) The Authority shall issue certification only to applicants that meet the criteria in OAR 410-141-3015, meet the requirements, and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an applicant is eligible for certification when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:

(A) Provides or will provide the coordinated care services in the manner described in the RFA and the Authority's rules;

(B) Is responsible and meets or will meet standards established by the Authority and DCBS for financial reporting and solvency;

(C) Is organized and operated and shall continue to be organized and operated in the manner required by the contract

and described in the application; and
(D) Shall comply with any assurances it has given the Authority.
(6) The Authority shall certify CCOs for a period of six years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.
(7) The Authority may determine that an applicant is potentially eligible for certification in accordance with section (9). The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient applicants eligible for certification are available to attain the Authority's objectives under the RFA.
(8) The Authority may determine that an applicant is potentially eligible for certification 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 of time; 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 certification. 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 certification cannot become certified within the time announced in the RFA for contract award, the Authority may:
(A) Offer certification at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for certification within the scope of the RFA; or
(B) Inform the applicant that it is not eligible for certification.
(9) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.
(10) The Authority shall enter into or renew a contract with a CCO only if the CCO has been certified 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;
(b) The number of CCOs in the region.
(11) 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) Only an entity that the Authority has certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO that it will be offered a contract;
(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified applicants in order 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;
(d) Subject to any limitations in the RFA, the Authority may renew a contract for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA;
(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.
(12) Disclosure of application contents and release of information:
(a) Except for the letter of intent to apply and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), information may not be disclosed to any

applicant or the public until the award date. 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, 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 (with the exception of 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.
(13) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the demonstration requirements. Upon approval of the demonstration by CMS, the Authority shall conduct jointly with CMS the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and the award of three-way contracts between CMS, the state, and applicants who have been certified to contract as a CCO and participate in the demonstration.
(14) 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.
(15) 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 January 1, 2012) to govern RFAs and certification and contracting with CCOs:
(a) OAR 137-046 — General Provisions Related to Public Contracting: OARs 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;
(b) OAR 137-047 — 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;
(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;
(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.
(16) 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: 414.615, 414.625, 414.635, 414.651, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3015

RULE TITLE: Certification Criteria for Coordinated Care Organizations

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Parity requirements.

RULE TEXT:

(1) Applicants shall submit applications to the Authority describing 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 use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO certification within the context of the Oregon Health Policy Board's report, Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation (Jan. 24, 2012).

(3) 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.

(4) 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;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will 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. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;

(b) Each criterion will be listed followed by the elements that shall be addressed during the initial certification described in this rule without limiting the information that is requested in the RFA concerning these criteria.

(6) 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 is used to

select governance structure members, and how it will assure 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 will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.
(7) 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 will be administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.
(8) 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 will 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 becoming certified;
(b) The applicant shall describe how it will develop 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 need that builds on community resources and skills and emphasizes innovation.
(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.
(10) Dental care organizations: On or before July 1, 2014, each CCO shall have a contractual relationship with any DCO in its service area.
(11) 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.
(12) CCOs shall provide integrated, personcentered care and services designed to provide choice, independence, and dignity:
(a) The applicant shall describe its strategy to assure that each member receives integrated, personcentered care and services designed to provide choice, independence, and dignity;
(b) The applicant shall describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.
(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall:
(a) Describe their planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, personal health navigators, and qualified community health workers where appropriate;
(b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.
(14) 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.
(15) 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 wellbeing of all members;
(b) Are 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) Are permitted to participate in the networks of multiple CCOs;
(e) Include providers of specialty care;
(f) Are 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 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 DHS Medicaid-funded long-term care services, 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.
(16) 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.
(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patientcentered 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.
(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate followup care when entering or leaving an acute care facility or long-term care setting. 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 will be 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.
(19) 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, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate, and community health workers.

(20) 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.
(21) Each CCO 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 severe 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.
(22) Each CCO shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.
(23) Each CCO shall implement to the maximum extent feasible patientcentered 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 patientcentered primary care homes in a timely manner using health information technology.
(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:
(a) Describe their strategy for 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) Engage 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) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.
(25) CCOs are encouraged to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.
(26) Each CCO 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 improvement plan for meeting transformation expectations;
(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.

(27) Each CCO shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the All Payer All Claims (APAC) data reporting system and follow expectations for participation in annual TQS reporting to the Authority as detailed in the MCE contract and external quality review with the Authority contracted External Quality Review Organization as outlined in CFR 42 §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 shall submit APAC data in a timely manner according to program specifications.
(28) Each CCO shall be transparent in reporting progress and outcomes. Applicants shall:
(a) Describe how it will assure transparency in governance;
(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that will be transparent and publicly reported and available on the Internet.
(29) Each CCO 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 will use 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.
(30) Each CCO 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 Insurance Division 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.
(31) Each CCO 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.
(32) A CCO 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.
(33) Each CCO shall provide covered Medicaid services, other than DHS Medicaid-funded long-term care services, to members who are dually eligible for Medicare and Medicaid.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

AMEND: 410-141-3030

RULE TITLE: Implementation and Transition

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: New 2390-F requirements to include Transformation and Quality (TQS) reporting and related subcontractor obligations.

RULE TEXT:

(1) Implementation of the Oregon Integrated and Coordinated Health Care Delivery System through CCOs is essential to achieve the objectives of health transformation and cost savings. The ability of CCOs to meet transformation expectations shall be phased in over time to allow CCOs to develop the necessary organizational infrastructure. During this implementation period, the Authority holds the following expectations:

(a) Contract provisions, including an approved Transformation and Quality Strategy (TQS) and work plan for implementing health services transformation, shall describe how the CCO must comply with transformation requirements under these rules throughout the term of the CCO contract to maintain compliance;

(b) Consistent with CFR 42 §438.230, §438.602(a) and §438.66, the CCO shall provide the Authority adequate documentation demonstrating monitoring of subcontractor compliance or subcontractor auditing as applicable, in accordance with CMS.

(2) Required subcontractor responsibilities are as follows:

(a) Program integrity and data submission requirements as noted in 42 CFR §438.604, §438.606, §438.608, §438.610;

(b) Subcontractor compliance with 42 CFR, Subpart F: Grievance and appeal system requirements;

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

(d) Linguistic and disability access for members as outlined in CFR 42 §438.10 and federal rule 1557.

(3) Local and community involvement is required, and the Authority shall work with CCOs to achieve flexibilities that may be appropriate to achieve community-directed objectives, including addressing health care for diverse populations.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

AMEND: 410-141-3070

RULE TITLE: Preferred Drug List Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Rule changes to align with 2390-F to specify MCE pharmacy prior authorization requirements and the constructs of the pharmacy and therapeutics (P&T) committee and the drug utilization review committee.

RULE TEXT:

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

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

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (14) and (15) of this rule;

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

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

(3) CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through prior authorization (PA).

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

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

(c) If the issuer has more than one plan, the member 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) CCOs shall cover at least one form of contraception within each of the eighteen methods identified by the FDA. As set forth in OAR 410-141-3320, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating provider.

(8) CCOs shall provide their participating providers and their pharmacy subcontractor with:

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

(b) Updates made to their drug list within 30 days of a change that may include but are not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(9) Prior Authorization for prescription drug requests shall be addressed by the MCEs in the following manner:

(a) Responding to prior authorizations for prescription drugs within 24 hours as described in CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. A response may include:

(A) A request for additional documentation when the prior authorization request lacks sufficient information or documentation to render a decision;

(B) If the necessary additional documentation is not received within 72 hours of the response, the prior authorization may be denied;
(C) The CCO shall make a decision within 24 hours of receiving the necessary information if additional information or documentation is received;
(D) If a substantiated medical emergency justifies the immediate medical need for the drug during this review process, an emergency 72-hour supply shall be made available until the CCO makes a final coverage decision.
(b) Requests shall be addressed by the MCEs by:
(A) Responding to the requestor by telephone or other telecommunication device within 24 hours of a request for prior authorization; and
(B) Contacting the provider within two working days of receipt of the request. The MCE shall notify providers in writing of an approval or a denial, as outlined in OAR 410-141-3240.
(10) CCOs 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) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.
(12) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List.
(13) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:
(a) The drug name;
(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and
(c) The reason the Authority should consider this drug for carve out.
(14) If a CCO requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.
(15) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). A CCO may not reimburse providers for carved-out drugs.
(16) CCOs shall submit quarterly utilization data within 45 days after the end of the quarter pursuant to 42 CFR 438.3
(17) CCOs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.
(18) CCOs shall utilize a pharmacy and therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, as long as all committee requirements for both committee types are met. 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. CCO's 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.
(19) 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

AMEND: 410-141-3120

RULE TITLE: Operations and Provision of Health Services

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: OAR 410-141-3120 Operations and Provision of Health Services provides the requirement language for the Oregon Common Credentialing Application as the predecessor to the Oregon Common Credentialing program to be implemented later in 2018.

RULE TEXT:

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, CCOs shall provide medically appropriate health services including other health related services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the contract.

(3) 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. Pursuant to OAR 409-045-0025 through 409-045-0135, CCOs shall participate in the Oregon Common Credentialing Program to obtain verified credentialing information for health care practitioners.

(b) CCOs shall direct health care practitioners that must be credentialed to the Oregon Common Credentialing Program's electronic system to submit and maintain their credentialing information.

(c) 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;

(d) 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.

(e) Each contract or written arrangement must specify that:

(A) If any of the CCO activities or obligations under its contract with the state are delegated to a subcontractor:

(i) The delegated activities or obligations and related reporting responsibilities are specified in the contract or written agreement;

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

(iii) Contracted or written arrangements must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the state or the CCO determine that the subcontractor has not performed satisfactorily.

(B) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

(f) 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").
(g) CCOs may not refer members to or use providers that:
(A) Have been terminated from the Division;
(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.
(h) 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;
(i) 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);
(j) 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.
(4) 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.
(5) 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.

(6) 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.
(7) 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

AMEND: 410-141-3160

RULE TITLE: Integration and Care Coordination

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To align with OAR with CMS 2390-F requirements and to rewrite the rule for better flow and usability.

RULE TEXT:

(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 (CHA) and community health improvement plan (CHP).

(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) At a minimum, populations shall include members with special health needs, the aged, blind, disabled, members who have complex medical needs, multiple chronic conditions, mental illness, or chemical dependency, or receive Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(4) Upon initial enrollment with the CCO, the MCE shall make a best effort, three attempts, two methods, to conduct for each member an initial health risk screening, which is different from the assessment of special health care needs. MCEs shall document all attempts to reach the member by telephone and mail to demonstrate compliance. This screening shall be completed and documented within 90 days of the effective date of enrollment for all new members, including subsequent attempts if needed, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS or as quickly as the member's health condition requires.

(5) MCEs shall have processes to ensure review of member's potential need for long term services and supports and identify appropriate members for referrals to DHS for long-term services and supports;

(6) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document in the member's record and share the results of its health risk screening identifications appropriate for ICC services:

(a) With participating providers serving the member;

(b) With the state or other MCEs serving the enrollee;

(c) With members receiving Medicaid-funded long-term care or long-term services and supports; and

(d) With Medicaid Advantage plans serving dual eligible members;

(e) Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(7) MCEs shall ensure that members assessed with high health needs, multiple chronic conditions, behavioral health issues, or receiving Medicaid funded long-term care or long-term services and supports are:

(a) Provided ICC services in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(b) Provided contact information for any ICC staff or formally designated person or entity with the primary responsibility for coordinating the services with the member;

(c) MCEs shall monitor subcontractors to ensure language and disability access are provided consistently across services and settings of care.

(8) For members with special health care needs determined through a health risk screening, MCEs shall have a process to allow enrollees 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.

(9) MCEs shall have processes to receive referrals for members receiving long-term care or long-term services and supports from DHS and referrals for health assessment intensive care coordination within 30 days, or as quickly as the member's health condition requires.

(10) MCEs shall produce a treatment or service plan for members with special health care needs, including members receiving LTC or LTSS that are determined through assessment to need a course of treatment or regular care monitoring:
(a) Such treatment plans shall be developed with any providers caring for the member, including any community-based support services; and
(b) Include consultations with any specialist caring for the member and DHS long-term care or long-term services and supports, providers, or case managers:
(A) MCEs shall share information as needed to prevent duplication of efforts with DHS Aging and People with Disabilities and the Office of Developmental Disability Services for members enrolled in other MCEs; and
(B) With Medicare Advantage plans serving dual eligible members to reduce duplication of assessment and care planning activities among entities serving the member.
(c) MCEs shall use and require its 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 severe and persistent mental illness receiving home and community-based services covered under the state's 1915(I) State Plan Amendment and those receiving DHS Medicaid-funded long-term care services. Plans shall reflect member family or caregiver preferences and goals to ensure engagement and satisfaction and ensure authorization of services reflects rules outlined in OAR 410-141-3225 MCE Service Authorization.
(11) MCEs shall coordinate 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.
(12) MCEs shall develop evidence-based or innovative 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.
(13) To the maximum extent feasible, CCOs 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.
(14) 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;
(b) Ensure that each member has an ongoing source of care appropriate to his or her 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:

(A) MCE members who are Indians (AI/AN) 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;
(B) An out-of-network IHCP may refer a MCE member who is an Indian to an in-network provider without prior authorization or referral from a participating provider.
(d) MCEs shall maintain contracts with providers of residential chemical dependency treatment services and notify the Authority within 30 days of executing new contracts;
(e) MCEs shall maintain a contractual relationship with any dental care organizations necessary to provide adequate access to dental services in the area where members reside;
(f) MCE's shall assess the needs of its membership and make available supported employment and assertive community treatment services available when medically appropriate and when an appropriate provider is available. Appropriate providers are those that meet the requirements in OAR 309-016-0825. When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to make supported employment and assertive community treatment services available.
(15) MCEs shall have adequate, timely, and appropriate access to hospital and specialty services. 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.
(16) 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.
(17) When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service or PHP to a 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.
(18) 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.
(19) 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 DHS office and begin appropriate discharge planning. The MCE shall pay for the post-hospital extended care benefit 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;
(b) For members who are discharged to Medicare Skilled Care, the MCE shall notify the appropriate DHS 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 DHS Medicaid-funded long-term care by communicating with local DHS offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care (LTC) settings.
(20) 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 and how it will work 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 long-term care or long-term services and supports;
(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 mental health services, some of which are not provided under the global budget.
(21) A CCO may cover and reimburse inpatient psychiatric services, but not including substance use disorder treatment, at an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010. (See OAR 410-141-3000 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 CCO 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 CCO contract and may be offered to members at the CCO's option.
(22) If the member is living in a DHS Medicaid funded long-term care (LTC) nursing facility or community-based care facility or other residential facility, the MCE shall communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services.
(23) An MCE shall demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities).
(24) 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.
(25) 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.
(26) 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 410-141-3050 for program specific rules.
(27) Except as provided in OAR 410-141-3050, 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.
(28) 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 410-141-3225 MCE Service Authorization.
(29) MCEs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional, as defined in OARs 410-120-0000, 410-141-3225, or 410-141-3240; and shall ensure a notice of action/adverse benefit determination notice is issued for an adverse benefit determination or service authorization denial, including request for referrals that are denied.
(30) 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.
(31) MCEs shall accept FFS authorized services, medical, and pharmacy prior authorizations; ongoing services where a FFS prior authorization is not required; and services authorized by the Division's Medical Management Review Committee. This shall occur within 90 days or until the MCE can establish a relationship with the member and develop an evidence-based, medically appropriate coordinated care plan, whichever is later. The exception is when customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610–414.685

AMEND: 410-141-3170

RULE TITLE: Intensive Care Coordination (ICC) Services (Exceptional Needs Care Coordination (ENCC))

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To align with OAR with CMS 2390-F requirements and to rewrite the rule for better flow and usability.

RULE TEXT:

(1) MCEs are responsible for intensive care coordination (ICC) services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the MCE uses another term, these rules set forth the elements and requirements for ICC services. Where the term ENCC appears in rule or contract, it shall be given the meaning in this rule.

(2) MCEs shall make ICC services available to members identified as aged, blind, disabled, or members with complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports receiving home and community-based services under the state's 1915(i) State Plan Amendment. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(3) The member, member's representative, provider, or other medical personnel serving the member or the member's Long Term Care (LTC) or Long Term Service and Supports (LTSS) case manager may refer or self-refer the member for a health risk screening for ICC services.

(4) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.

(5) Upon initial enrollment with the CCO, the MCE shall conduct an initial health risk screening for each new member, which is different from the assessment of special health care needs. This screening shall be completed and documented 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 LTC or LTSS, or as quickly as the member's health condition requires. MCEs shall maintain documentation on the risk screening process used for compliance. If the risk screening requires additional information from the member, MCEs shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.

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

(7) MCEs shall implement procedures to share the results of its screening identifications and treatment plans appropriate for ICC services with participating providers serving the member. Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(8) MCEs shall implement an information sharing process to reduce duplication of services among entities serving members, including members receiving Medicaid-funded long-term care or long-term services and supports and other MCEs serving members with Medicare Advantage plans serving dual eligible members.

(9) Such care coordination activities include:

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

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

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

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

(f) Subcontractors shall be monitored to ensure language and disability access are provided consistently across services and settings of care.

(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.

(11) For members receiving Medicaid-funded long-term care or long-term services and supports, MCEs shall share

information as needed with DHS Aging and People with Disabilities and Office of Developmental Disability Services for members enrolled in other MCEs and with Medicare Advantage plans serving dual eligible members. Each treatment plan shall be:
(a) Developed by the member's designated provider with the member's participation;
(b) Include consultations with any specialist caring for the member and DHS long-term care or long-term services and supports providers or case manager;
(c) Approved by the MCE in a timely manner if MCE approval is required;
(d) In alignment with rules outlined in OAR 410-141-3225 MCE Service Authorization; and
(e) In accordance with any applicable quality assurance and utilization review standards.
(12) The member, member's representative, provider, other medical personnel serving the member, or the member's DHS case manager may request ICC services.
(13) MCEs shall have processes to receive referrals for health care assessments.
(14) MCEs shall refer members to ICC for a health assessment within 30 days when the member referred is receiving Medicaid LTC or LTSS or as quickly as the member's health condition requires.
(15) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.
(16) MCEs shall make ICC services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting.
(17) 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.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3180

RULE TITLE: Record Keeping and Use of Health Information Technology

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: To update the record retention requirements.

RULE TEXT:

(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., and 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.

(2) 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. 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 following coordinated care services and supports:

(a) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery;

(b) The supportive and therapeutic needs of the member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;

(c) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility, including acute psychiatric facility, state hospital, or residential care settings for members with mental illness or a Department Medicaid funded long-term care setting, including engagement of the member and family in care management and treatment planning;

(d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources; for example, the use of certified or qualified health care interpreters, as defined in ORS 413.550, community health workers, and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;

(e) Members have access to advocates; for example, qualified peer wellness specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the

member's care and services;
(f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
(6) MCEs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, MCEs shall:
(a) Identify EHR adoption rates. Rates may be divided by provider type and geographic region;
(b) Develop and implement strategies to increase adoption rates of certified EHRs;
(c) Encourage EHR adoption.
(7) MCEs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and dental health information with any other provider in that MCE.
(8) MCEs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
(9) MCEs shall initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:
(a) Analytics that are regularly and timely used in reporting to its provider network (e.g. to assess provider performance, effectiveness and cost-efficiency of treatment);
(b) Quality and utilization reporting to facilitate quality improvement within the MCE as well as to report the data on quality of care that will allow the Authority to monitor the MCEs performance;
(c) Patient engagement through HIT, using existing tools such as e-mail; and
(d) Other appropriate uses for HIT (e.g. telehealth, mobile devices).
(10) MCEs shall maintain health information systems that collect, analyze, integrate, and report data and are able to provide information on areas including but not limited to the following:
(a) Names and phone numbers of the member's primary care provider or clinic, primary dentist, and behavioral health provider;
(b) Copies of Client Process Monitoring System (CPMS) enrollment forms;
(c) Copies of long-term psychiatric care determination request forms;
(d) Evidence that the member has been informed of rights and responsibilities;
(e) Complaint and appeal records;
(f) Disenrollment requests for cause and the supporting documentation;
(g) Coordinated care services provided to enrollees through an encounter data system; and
(h) 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. The system shall conform to accepted professional practices and facilitate an adequate system to allow the MCE to ensure that data received from providers is accurate and complete by:
(A) Verifying the accuracy and timeliness of reported data;
(B) Screening the data for completeness, logic, and consistency; and
(C) Collecting service information in standardized formats to the extent feasible and appropriate.
(11) 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.
(12) 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. Contractors 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 contractor's performance. All clinical records, financial records, other records, books, documents, papers, plans, records of shipments, and payments and writings of the contractor 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.

(13) MCEs shall allow access to the agencies listed in section (12) 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.

(14) MCEs shall allow access to the entities listed in section (12) 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.

(15) MCEs must maintain yearly logs of all appeals and grievances for ten years following requirements specified in OAR 410-141-3255.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3200

RULE TITLE: Outcome and Quality Measures

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Rule requires those plans accredited to report such accreditation to OHA and inclusion of External Quality Review (EQR) requirements.

RULE TEXT:

(1) CCOs 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 contractor shall inform the Authority if it has been accredited by a private independent accrediting entity. If the contractor has been so accredited, the contractor shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review.

(3) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority. The measures are adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

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

(5) CCOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the CCO's community health assessment, community health improvement plan, and the standards in the CCO's contract. CCOs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with CCO 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 410-141-3245 through 410-141-3248; and

(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, mental illness, or Substance Use Disorders (SUD); 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.

(6) CCOs shall implement policies and procedures that assure it will collect timely data including health disparities and other data required by rule or contract that will allow the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(7) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 and the CCO contract that addresses assigned contractual responsibilities for physical health care, behavioral healthcare, 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 410-141-3160; 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) CCOs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures will be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts;
(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
(9) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the CCO agreement.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3220

RULE TITLE: Accessibility

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: MCE access requirements.

RULE TEXT:

(1) Consistent with the community health assessment and health improvement plan, MCEs must assure that members have access to high quality care. The MCE shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The MCE shall develop and implement the assessment and plan over time that meets access-to-care standards and allows for appropriate choice for members. The goal shall be that services and supports should be geographically 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.

(2) MCEs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the MCE should anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered approach. The MCE 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.

(4) MCEs shall have policies and procedures that ensure 90 percent of their members in each service area have routine travel time or distance to the location of the PCPCH or PCP that does not exceed the community standard for accessing health care participating providers. The travel time or distance to: PCPCHs 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; dental, adult and pediatric; and additional provider types when it promotes the objectives of the Authority may not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas-30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas-60 miles, 60 minutes or the community standard, whichever is greater.

(5) MCEs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) 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 members within the same service area. If the MCE is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. MCEs shall have a monitoring system that shall demonstrate to the Authority that the MCE has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) 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 over utilizes services;

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

(7) 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, behavioral health issues, or who are children receiving Department or OYA services have access to primary care, dental care (when the MCE or DCO is

responsible for dental care), mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.
(8) 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 as within the following timeframes:
(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 410-141-0140;
(c) Well care, within four weeks or within the community standard;
(d) Emergency dental care (when dental care is provided by the MCE or DCO), seen or treated within 24-hours;
(e) Urgent dental care (when dental care is provided by the MCE or DCO), within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and
(f) Routine dental care (when dental care is provided by the MCE or DCO), seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason that would make access longer than 12 weeks appropriate;
(g) Non-Urgent behavioral health treatment, seen for an intake assessment within two weeks from date of request.
(9) MCEs shall develop policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or there is no telephone:
(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in MCE administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;
(b) MCEs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health, or dental care (when the MCE or DCO is responsible for dental care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint, make a diagnosis, respond to member's questions and concerns, and communicate instructions to the member;
(c) MCEs shall ensure the provision of coordinated care services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;
(d) MCEs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non-participating referral providers when necessary;
(e) MCEs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

STATUTORY/OTHER AUTHORITY: 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

ADOPT: 410-141-3225

RULE TITLE: MCE Service Authorization

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(1) Coverage of services is outlined by MCE contract and OHP benefits coverage outlined 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 in order to gain access to mental health or substance use disorders assessment and evaluation services. A member may self-refer to mental health and substance use disorders services available from the provider network.

(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 410-141-0520.

(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 410-141-3240 (Notice of Action/Adverse Benefit Determination Notice Requirements).

(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 the purpose of 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 so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

(9) Authorization of services:

(a) Each MCE shall follow the following timeframes for authorization requests:

(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 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 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 time 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) 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;
(c) 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 action/adverse benefit determination shall be issued on the date the timeframe expires;
(d) 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 410-141-3240;
(e) 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 appropriate:
(i) Requesting all the appropriate information to support plan 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 appropriate clinical expertise in addressing the member's medical, behavioral health, or dental needs or in consultation with a health care professional with appropriate clinical expertise in treating the member’s condition or disease. This applies to decisions:
(i) To deny a service authorization request;
(ii) To reduce a previously authorized service request; or
(iii) To 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 time frames 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.
(f) Prior authorization for prescription drug requests shall be addressed by the MCEs in the following manner:
(A) Responding to prior authorizations for prescription drugs within 24 hours as described in CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Act. A response may include:
(i) A request for additional documentation when the prior authorization request lacks sufficient information or

documentation to render a decision;
(ii) The MCE shall make a decision within 24 hours of receiving the necessary information, if additional information or documentation is received;
(iii) If a substantiated medical emergency justifies the immediate medical need for the drug during this review process, an emergency 72-hour supply shall be made available until the MCE makes a final coverage decision.
(B) Requests shall be addressed by the MCEs by:
(i) Responding to the requestor by telephone or other telecommunication device within 24 hours of a request for prior authorization; and
(ii) Contacting the provider within two working days of receipt of the request. The MCE shall notify providers in writing of an approval or a denial, as outlined in OAR 410-141-3240.
(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 410-141-3240 unless otherwise specified in OHP program rules:
(A) MCEs shall make reasonable efforts, three attempts, 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

ADOPT: 410-141-3230

RULE TITLE: MCE Grievance and Appeals

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(1) For purposes of this rule and OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424, references to member means a member, the member's representative, and the representative of a deceased member's estate.

(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 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;

(b) 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;

(c) Member rights to file a grievance at any time for any matter other than an appeal or contested case hearing;

(d) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests.

(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) MCEs shall document appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3255 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;

(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 CFR 42 §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 or their representative 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 the grievance or appeal 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 410-141-3200 and 410-141-3230.
(7) MCEs shall keep all healthcare 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 qualified community health workers, qualified 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) Adjudication of appeals in a member grievance and appeals process may not be delegated.
(13) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman 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.
(14) 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 410-141-3250.
(15) If the MCE delegates the grievance and appeal process to a subcontractor, the MCE must:
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3025 through 410-

141-3255;

(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

ADOPT: 410-141-3235

RULE TITLE: MCE Grievance Process Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(1) A member may file a grievance at any time either orally or in writing. The grievance may be sent to the MCE or to the Authority. If the grievance is sent to the Authority, it shall be promptly forwarded to the MCE.

(2) For a standard resolution of grievances, 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 that a decision on the grievance has been made and what that decisions is; or

(b) Notify the member 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 410-141-3230 MCE Grievance and Appeals System General Requirements.

(4) When informing members of the MCE's decision, the MCE:

(a) May provide its decision related to oral grievances either orally or in writing;

(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 addition to written responses, the MCE may also respond orally;

(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 Ombudsman.

(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, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

(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 for reasons defined in OAR 410-141-3080 (15), 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

ADOPT: 410-141-3240

RULE TITLE: Notice of Action-Adverse Benefit Determination Notice Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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 410-141-3300 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, the member's authorized representative, or the member's provider outlined in OAR 410-141-3225 MCE Service Authorization or otherwise specified in this rule;

(c) Meet the content notice requirements of 42 CFR §438.404 including but not limited to the following:

(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;

(J) Clear and thorough explanation of the specific reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:

(i) The item requiring prior authorization but not authorized;

(ii) The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-000;

(iii) The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;

(iv) The service or item received in an emergency care setting that does not qualify as an emergency service;

(v) The person not a member at the time of the service or not a member at the time of the requested service;

(vi) Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;

(vii) Prior approval not obtained (except as allowed in OAR 410-141-3140); or

(viii) MCE denial of member's disenrollment request and findings that there is no good cause for the request.

(K) Information regarding the member's rights to be provided upon request and at no cost and 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;

(L) Information about the member's or the provider's right to file an appeal with the MCE; the right to request a contested case hearing only after the MCE Appeal Notice of Resolution or where the MCE failed to meet appeal timelines as outlined in OAR 410-141-3230; and procedures for exercising these rights in OAR 410-141-3245;
(M) An explanation of circumstances under which the member or the member's provider may request and process for an expedited appeal; and
(N) A statement that the member has the right to request the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the MCE's Notice of action.
(d) The Notice shall be on 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 include the appropriate forms based on the Authority-approved Notice of Action/Adverse Benefit Determination as outlined in OAR 410-141-3240. The appropriate forms are:
(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.
(6) 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: 414.615, 414.625, 414.635, 414.651, 414.032

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

ADOPT: 410-141-3245

RULE TITLE: MCE Appeal Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(1) A member or a subcontractor or provider with the member's written consent who disagrees with an adverse benefit determination or is contesting the failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals may file an appeal with the MCE.

(2) 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.

(3) 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.

(4) As noted in OAR 410-141-3225 MCE Service Authorization, all notice of actions/adverse benefit determination notices shall provide information on member rights to appeal and request an MCE review of the notice including the ability of providers and authorized representatives to appeal on behalf of a member:

(a) If after filing an oral appeal, a member or the provider on the member's behalf does not submit a written appeal request within the appeal timeframe, the appeal shall expire;

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

(c) The MCE does not need to notify the member if the MCE has already made attempts to assist the member in filling out the necessary forms to file a written appeal.

(5) For purposes of this rule, an appeal includes a request from the Division 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;

(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.

(7) The MCE shall have written policies and procedures for handling appeals that:

(a) Address how the MCE shall accept, process, and respond to appeals, including how the MCE will acknowledge receipt of each appeal;

(b) Ensure members who receive a notice are informed of their right to file an appeal and how to do so as set forth in OAR 410-141-3245;

(c) Ensure each appeal is transmitted timely to staff having authority to act on it;

(d) 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;
(e) Ensure each appeal is investigated and resolved in accordance with these rules;
(f) Ensure the individuals who make decisions on appeals follow all requirements in OAR 410-141-3230 MCE Grievance and Appeals System General Requirements;
(g) Document appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3230 MCE Grievance and Appeals System General Requirements and OAR 410-141-3255 Grievance and Appeals System Recordkeeping Requirements, consistent with 42 CFR §438.416;
(h) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing:
(A) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard appeals and in the case of a request for expedited appeals resolution;
(B) 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.
(8) Parties to the appeal include:
(a) The MCE;
(b) The member and the member's representative, if applicable;
(c) The legal representative of a deceased member's estate.
(9) The MCE shall resolve each standard appeal in the 16 day time period and provide the member and the member's representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within 72 hours for matters that meet expedited appeals reasons.
(10) The member requests the extension or the MCE shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the member's interest. If the MCE extends the timeframes, it shall, for any extension not requested by the member, give the member a written notice of the reason for the delay.
(11) 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.
(12) 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.
(13) The written notice of appeal resolution shall be in a format approved by the Authority and include the following information:
(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) The appropriate forms are:
(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.
(14) A member may request a contested case hearing not later than 120 days from the date on the MCE Notice of

Appeal Resolution.

(15) If the contested case hearing request was made directly by the member or their representative to the Authority, the MCE shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's request.

(16) Required Documentation:

(a) The MCE's records of an appeal shall include, at a minimum, a log of all appeals received by the MCE containing the following information:

(A) Member's name and Medical Care ID number;

(B) Date of the original Notice of Action/Adverse Benefit Determination;

(C) Notice of Appeal Resolution;

(D) Date and nature of the appeal;

(E) Whether continuing benefits were requested and provided; and

(F) Resolution and resolution date of the appeal.

(b) The MCE shall maintain a complete record for each appeal included in the log for no less than 300 days to include:

(A) Records of the review or investigation; and

(B) Resolution including all written decisions and copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or the member's provider as part of the appeal process.

STATUTORY/OTHER AUTHORITY: 413.032

STATUTES/OTHER IMPLEMENTED: 414.065

ADOPT: 410-141-3246

RULE TITLE: Expedited MCE Appeal Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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 administrative hearing and send the member an approved Notice of Appeal Resolution, Hearing Request and Information forms as set forth in OAR 410-141-3247.

(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

ADOPT: 410-141-3247

RULE TITLE: Contested Case Hearings Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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. 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.

(2) The member may not request a hearing without first filing an appeal with their MCE. The member shall file a hearing request using form MSC 0443 with the Authority 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 410-141-3248.

(3) A member may request a contested case hearing with the Authority after receiving notice that the MCE notice of action/adverse benefit determination is upheld or, in the case of an MCE that fails to adhere to the notice and timing requirements in 42 CFR §438.408, the Authority may consider that the member has exhausted the MCE's appeals process and may initiate a contested case hearing.

(4) A request for a contested case hearing made prior to MCE appeal by the member or provider shall be forwarded by the Authority to the MCE for review, except in the case where the Authority determines the MCE failed to act within required timelines.

(5) In such cases, the MCE shall receive notice of the Authority's decision to allow the member access to a contested case hearing under the administrative procedures act for failure to adhere to the notice and timing requirements in 42 CFR §438.408.

(6) When a member files a hearing request with the state prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures outlined in this rule above.

(7) 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. Due to operational conflicts, the procedures needing revision, and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a) that allows hearing requests to be treated as timely based on the date of postmark does not apply to MCE member contested case hearing requests.

(8) If the member files a request for an appeal or hearing with the Authority prior to the member filing with the MCE, 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;

(b) Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.

(9) 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:

(A) A copy of the hearing request, notice of action/adverse benefit determination, and notice of appeal resolution;

(B) 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 141-410-3245.

(10) A member's provider may request a hearing about an action affecting the provider. The provider shall resolve an appeal with the MCE before requesting a hearing. As stated in OAR 410-141-3245, in addition to the member, a

subcontractor or provider with the member's written consent may file an appeal with the MCE if:
(a) There is disagreement with an adverse benefit determination;
(b) The subcontractor or provider is contesting the failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(11) The MCE shall approve or deny the appeal within 30 days and provide the subcontractor or provider with a notice of appeal resolution.
(12) The subcontractor or provider appealing for reasons set forth in OAR 410-120-1560 Provider Appeals shall file a hearing request with the Authority no later than 30 days from the date of the MCE's notice of appeal resolution, unless the provider is completing the appeal on behalf of the member, pursuant to OAR 410-120-1560.
(13) The parties to a contested case hearing include the following:
(a) The MCE and the member or the member's representative requesting a hearing; or
(b) The MCE and the member's provider.
(14) 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 Division-approved appeal or hearing request forms.
(15) 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. This does not include the number of days the member took to subsequently file a contested case hearing request.
(16) 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

ADOPT: 410-141-3248

RULE TITLE: Expedited Contested Case Hearings

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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 filing an appeal or expedited appeal with the MCE. 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 410-141-3247.

(4) Expedited hearings are requested using Authority form MSC 443 or other Division approved appeal or hearing request forms.

(5) The MCE shall submit relevant documentation to the Authority within two working days of any decision of an expedited appeal. The Authority shall decide within two working days from the date of receiving the medical documentation applicable to the request 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

ADOPT: 410-141-3250

RULE TITLE: Continuation of Benefits

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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 no later than:

(A) The tenth day following the date of the notice of action/adverse benefit determination or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness, delay for good cause as defined in OAR 137-002-0528 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) 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) 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

ADOPT: 410-141-3255

RULE TITLE: Grievance and Appeals System Recordkeeping

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Alignment of Grievance System OARs with CMS 2390-F requirements and complete rewrite and renumbering of rule sets 410-141-3225-410-141-3255.

RULE TEXT:

(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 with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the MCE's review, resolution or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the MCE is aware of this;

(E) The log must contain a general description of the reason for an appeal.

(b) For each year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(3) The MCE must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(4) MCES shall submit to the Authority's Contract Administration Unit, with the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination. The recommended sample size is twenty per quarter per MCE.

(5) The MCE shall submit, 45 days following the end of each quarter, a Grievance System Report in a format and to a location acceptable to the Authority and identified in the MCE contract.

(6) The MCE shall incorporate data collected from monitoring of its grievance system to analyze its Grievance System, including all grievances and appeals data reported by the MCE in the Grievance and Appeal Log.

(7) The analysis of the Grievance System shall demonstrate how the MCE uses data collected by the MCE, its sub-delegates, and its providers to maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members. The MCE shall address all sections in the Grievance System Report template provided by The Authority.

(8) 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

REPEAL: 410-141-3260

RULE TITLE: Grievance System: Grievances, Appeals and Contested Case Hearings

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.

(2) The CCO must establish and have a Division approved process and written procedures for the following:

(a) Member rights to appeal and request a CCO's review of an action;

(b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and

(c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

(d) An explanation of how CCOs shall accept, process and respond to appeals, hearing requests and grievances;

(e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.

(3) Upon receipt of a grievance or appeal, the CCO must:

(a) Acknowledge receipt to the member;

(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;

(d) Ensure staff making decisions on the grievance or appeal are:

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

(B) Health care professionals as defined in OAR 410-120-0000 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.

(4) The CCO must analyze all grievances, appeals and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.

(5) CCOs must keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment or CCO health care operations are defined in 45 CFR 164.501.

(6) The following pertains to release of a member's information:

(a) The CCO 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.

(b) If the CCO needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must 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 qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services;

(c) 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.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal or hearing process;
(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.
(9) In all CCO administrative offices and in those physical, behavioral and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must have the following forms available:
(a) OHP Complaint Form (OHP 3001);
(b) Appeal forms;
(c) Hearing request form (DHS 443) and Notice of Hearing Rights (DMAP 3030); or
(d) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form (DMAP 3302) or approved facsimile.
(10) A member's provider:
(a) Acting on behalf of and with written consent of the member may file an appeal;
(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.
(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests and grievances including providing all requested written materials.
(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;
(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.
(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:
(a) The logs must contain the following information pertaining to each member's appeal or grievance:
(A) The member's name, ID number, and date the member filed the grievance or appeal;
(B) Documentation of the CCO's review, resolution or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;
(C) Notations of oral and written communications with the member; and
(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.
(b) For each calendar year, the logs must contain the following aggregate information:
(A) The number of actions; and
(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.
(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.
(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:
(a) Life, health, mental health or dental health; or
(b) Ability to attain, maintain or regain maximum function.
(16) 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 must complete a hearing request or request for appeal requesting continuing benefits no later than:
(A) The tenth day following the date of the notice or the notice of appeal resolution; and
(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay for good cause, as defined in OAR 137-002-0528, is not counted;
(c) The benefits must be continued until:
(A) A final appeal resolution resolves the appeal unless the member requests a hearing with continuing benefits no later than ten days following the date of the notice of appeal resolution;
(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 hearing.
(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.
(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

STATUTORY/OTHER AUTHORITY: ORS 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 – 414.685

REPEAL: 410-141-3261

RULE TITLE: CCO Grievance Process Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) A member may file a grievance:

(a) Orally or in writing; and

(b) With the Authority or the CCO. The Authority shall promptly send the grievance to the CCO.

(2) The CCO must resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:

(a) Within 5 working days from the date of receipt of the grievance; or

(b) If the CCO needs additional time to resolve the grievance, the CCO shall respond within 30 calendar days from the date of receipt of the grievance. If additional time is needed the CCO shall notify the member, within 5 working days, of the reasons additional time is necessary.

(3) When informing members of the CCO's decision the CCO:

(a) May provide its decision about oral grievances either orally or writing;

(b) Must address each aspect of the grievance and explain the reason for the decision; and

(c) Must respond in writing to written grievances. In addition to written responses, the CCO may also respond orally.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3262

RULE TITLE: Requirements for CCO Appeal

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) A member, their representative, or a subcontractor/provider with the member's consent, who disagrees with a notice of action (notice), has the authority to file an appeal with their CCO.

(2) For purposes of this rule, an appeal includes a request from the Division to the CCO for review of action.

(3) The member may request an appeal either orally or in writing directly to their CCO for any action by the CCO. Unless the member requests an expedited resolution, the member must follow an oral filing with a written, signed, and dated appeal.

(4) The member must file the appeal no later than 45 calendar days from the date on the notice.

(5) If after filing an oral appeal, a member does not submit a written appeal request within the appeals timeframe, the appeal will expire.

(6) The CCO does not need to notify the member if the CCO has already made attempts to assist the member in filling out the necessary forms to file a written appeal as required by rule.

(7) The CCO shall have written policies and procedures for handling appeals that:

(a) Address how the CCO will accept, process, and respond to such appeals, including how the CCO will acknowledge receipt of each appeal;

(b) Ensure that members who receive a notice are informed of their right to file an appeal and how to do so;

(c) Ensure that each appeal is transmitted timely to staff having authority to act on it;

(d) Consistent with confidentiality requirements, ensure that the CCO's staff person who is designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt of the appeal;

(e) Ensure that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensure that the individuals who make decisions on appeals are:

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

(B) Health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues.

(g) Include a provision that the CCO must document appeals in an appeals log maintained by the CCO that complies with OAR 410-141-3260 and consistent with contractual requirements;

(h) Ensure oral requests for appeal of an action are treated as appeals to establish the earliest possible filing date for the appeal; and

(i) Ensure the member is informed that they must file in writing unless the person filing the appeal requests expedited resolution;

(j) Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

(k) Provide the member an opportunity before and during the appeals process to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

(8) Parties to the appeal include:

(a) The CCO;

(b) The member and the member's representative, if applicable;

(c) The legal representative of a deceased member's estate.

(9) The CCO shall resolve each appeal and provide the member and their representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within the following periods for:

(a) Standard resolution of appeal: No later than 16 calendar days from the day the CCO receives the appeal;

(b) Expedited resolution of appeal (when granted by the CCO): No later than three working days from the date the CCO receives the appeal. In addition, the CCO must:
(A) Inform the member and their representative of the limited time available;
(B) Make reasonable efforts to call the member to tell them of the resolution within three calendar days after receiving the request; and
(C) Mail written confirmation of the resolution to the member within three calendar days.
(c) In accordance with 42 CFR 438.408, the CCO may extend these timeframes from subsections (a) or (b) of this section up to 14 calendar days if:
(A) The member or their representative requests the extension; or
(B) The CCO shows (to the satisfaction of the Division's Hearing Unit, upon its request) that there is need for additional information and how the delay is in the member's interest;
(C) If the CCO extends the timeframes, it must for any extension not requested by the member, give the member or their representative written notice of the reason for the delay.
(10) For all appeals, the CCO must provide written notice of appeal resolution to the member and also to their representative when the CCO knows there is a representative for the member.
(11) The written notice of appeal resolution must include the following information:
(a) The results of the resolution process and the date the CCO 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) Unless the appeal was referred to the CCO from the Division as part of a contested case hearings process, the right to request a hearing and how to do so;
(C) The right to request to receive benefits while the hearing is pending and how to do so; and
(D) That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCO's Action.
(12) Unless the appeal was referred to the CCO as part of a contested case hearing process, a member may request a hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution.
(13) If the appeal was referred to the CCO from the Division as part of a contested case hearing process within two business days from the date of the appeal resolution, the CCO must transmit the:
(a) Notice of Appeal Resolution; and
(b) Complete record of the appeal to the Division's Hearings Unit.
(14) If the appeal was made directly by the member or their representative, and the Notice of Appeal Resolution was not favorable to the member, the CCO must, if a contested case hearing is requested, submit the record to the Division's Hearings Unit within two business days of the Division's request.
(15) Documentation:
(a) The CCO's records must include, at a minimum, a log of all appeals received by the CCO and contain the following information:
(A) Member's name and Medical Care ID number;
(B) Date of the Notice;
(C) Date and nature of the appeal;
(D) Whether continuing benefits were requested and provided; and
(E) Resolution and resolution date of the appeal.
(b) The CCO shall maintain a complete record for each appeal included in the log for no less than 45 days to include:
(A) Records of the review or investigation; and
(B) Resolution, including all written decisions and copies of correspondence with the member.
(c) The CCO shall review the written appeals log on a monthly basis for:
(A) Completeness;
(B) Accuracy;

(C) Timeliness of documentation;
(D) Compliance with written procedures for receipt, disposition, and documentation of appeals; and
(E) Compliance with OHP rules.
(d) The CCO shall address the analysis of appeals in the context of quality improvement activity consistent with OAR 410-141-3200 — Outcome and Quality Measures and 410-141-3260 — Grievance System: Grievances, Appeals and Contested Case Hearings;
(e) The CCO shall have written policies and procedures for the review and analysis of all appeals received by the CCO. The analysis of the grievance system must be reviewed by the CCO's Quality Improvement Committee consistent with contractual requirements and comply with the quality improvement standards.

STATUTORY/OTHER AUTHORITY: ORS 413.032

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-3263

RULE TITLE: Notice of Action

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) A CCO must provide a member with a notice of action when the CCO's decision about a health service constitutes an action. The notice of action must:

(a) Be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the action and requesting a hearing;

(b) Comply with the Authority's formatting and readability standards;

(c) The notice must include but is not limited to the following:

(A) Date of the notice;

(B) CCO's name and telephone number;

(C) Name of the member's PCP, PCD, or behavioral health professional, as applicable;

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

(E) Service requested and whether the CCO is denying, terminating, suspending or reducing a service or payment;

(F) Date of the service or date the member requested the service;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the action if different from the date of the notice;

(I) Whether the CCO considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(J) Clearly and thoroughly explain specific reasons for the action and a reference to the specific sections of the statutes and rules pertaining to each reason;

(K) Member's right to file an appeal with the CCO or request a contested case hearing;

(L) An explanation of circumstances under which the member may request expedited resolution of an appeal, and how to request one; and

(M) A statement that the member has the right to request to receive the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the CCO's action;

(d) The Notice of Action must be on a Division approved form.

(2) The CCO must include the appropriate forms based on the Division approved Notice of Action, as outlined in OAR 410-141-3260, to the notice.

(3) For actions affecting previously authorized services, the CCO must mail the notice at least 10 calendar days before the date of action with the exception of circumstances described in section (4) of this rule.

(4) The CCO may mail the notice no later than the date of action if:

(a) The CCO or provider has information confirming the death of the member;

(b) The member sends the CCO a signed statement stating the member no longer wants the service;

(c) The CCO can verify that the member is in an institution where the member is no longer eligible for OHP services;

(d) The CCO is unaware of the member's whereabouts; the post office returns the mail indicating no forwarding address; and the Authority or Department of Human Services has no other address;

(e) The CCO verifies another state, territory, or commonwealth has accepted the member for Medicaid services;

(f) The member's PCP, PCD, or behavioral health professional has prescribed a change in the level of health services; or

(g) The date of action shall occur in less than 10 calendar days when the CCO:

(A) Has facts indicating probable fraud by the member, and the CCO has certified those facts, if possible, through a secondary resource; or

(B) Denies payment for a claim.
(5) For actions affecting services not previously authorized, the CCO must send the notice as expeditiously as the member's health condition requires but no later than 14 calendar days following the date of receipt of the request for service.
(6) For actions affecting services not previously authorized and for which the CCO grants expedited review, the CCO must send the notice as expeditiously as the member's health condition requires but no later than three business days after receipt of the request for service.
(7) In accordance with 42 CFR 438.408, the CCO may extend the timeframes from (5) above by up to 14 calendar days, if:
(a) The Division member or Division member's representative requests the extension; or
(b) The CCO shows (to the satisfaction of the Division's Hearings Unit upon it request) that there is need for additional information and how the delay is in the Division member's interest.
(8) If the CCO extends the timeframes, it must, for any extension not requested by the Division member, give the Division member and Division member's representative, a written notice of the reason for the delay.

STATUTORY/OTHER AUTHORITY: ORS 414.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 – 414.685

REPEAL: 410-141-3264

RULE TITLE: Contested Case Hearings

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Repealing due to the revision of the Oregon Medicaid General and Administrative rules that brings rules into compliance with the revised CMS Medicaid Managed Care rules under 2390-F and published on May 5, 2016.

RULE TEXT:

(1) A CCO must have a system in place to ensure its members and providers have access to appeal a CCO's action by requesting a 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.

(2) The member may request a hearing without first filing an appeal with their CCO. The member must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of action or notice of appeal resolution. If the member files the hearing request with the Department of Human Services or the CCO no later 45 days from the date of the notice, the Authority shall consider the request timely.

(3) In the event a request for hearing is not timely, the Authority shall determine whether the failure to timely file the hearing request was caused by circumstances beyond the member's control and enter an order accordingly. The member must submit a written statement explaining why the hearing request was late. The Authority may conduct further inquiry as the Authority deems appropriate. The Authority may refer an untimely request to the Office of Administrative Hearings (OAH) for a hearing on the question of timeliness;

(4) The CCO must conduct an appeal if the member requests an appeal without filing a request for hearing. If the member requests a hearing, without first requesting an appeal, the Authority may require the CCO to conduct an appeal prior to referring the matter to OAH.

(5) Effective February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in the division of rules in OAR 410 division 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to CCO hearing requests.

(6) If the member files a request for hearing with the Authority, the Authority shall provide a copy of the hearing request to the member's CCO. The CCO shall:

(a) Review the request immediately as an appeal of the CCO's action;

(b) Approve or deny the appeal within 16 calendar days, and provide the member with a notice of appeal resolution.

(7) If a member sends the hearing request to their CCO, the CCO must:

(a) Date-stamp the hearing request with the date of receipt; and

(b) Submit the following to the Authority within two business days:

(A) A copy of the hearing request, notice of action, and notice of appeal resolution, if applicable;

(B) All documents and records the CCO 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.

(8) A member's provider may request a hearing about an action affecting the provider. However, the provider must resolve an appeal with the CCO before requesting a hearing.

(a) The CCO must approve or deny the appeal within 16 calendar days, and provide the provider with a notice of appeal resolution.

(b) The provider must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of appeal resolution.

(9) The parties to a contested case hearing include the:

(a) CCO and the member requesting a hearing; or

(b) CCO and the member's provider if the provider requests a hearing.
(10) The Authority shall refer the hearing request along with the notice of action or notice of appeal resolution to OAH for hearing.
(11) The Authority must issue a final order or the Authority must resolve the case ordinarily within 90 calendar days from the earlier of the date:
(a) The CCO receives the member's request for appeal. This does not include the number of days the member took to subsequently file a hearing request; or
(b) The Authority receives the request for hearing.
(12) If a member requests an expedited hearing, the Authority shall request documentation from the CCO, and the CCO shall submit relevant documentation, including clinical documentation, to the Authority within two working days.
(13) The Authority must determine whether the member is entitled to an expedited hearing within two working days from the date of receipt of the medical documentation. If the Authority denies a request for an expedited hearing, the Authority must make reasonable efforts to:
(a) Call the member; and
(b) Send written notice within two calendar days.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3280

RULE TITLE: Managed Care Entity (MCE) Potential Member Information Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Removal of definitions out of 410-141-3280 for placement in OAR 410-141-3000. Informational requirements to Indians as potential MCE members. Informational requirements and formatting requirements for potential members of all eligibility categories.

RULE TEXT:

(1) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270 Oregon Health Plan Marketing Requirements.

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

(3) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(4) The following may not constitute marketing or 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.

(5) MCEs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm the information before the MCE may post.

(6) MCEs shall develop informational materials for potential members.

(7) MCEs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCE shall make available to potential members, upon request, information on participating providers.

(8) MCE provider directories for potential members shall include all specified elements and be made readily accessible as noted in OAR 410-141-3300. An MCE or the Authority may include informational materials in the application packet for potential members.

(9) MCEs shall include information for potential members stating that Indians (AI/AN) 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 Indian health care provider (IHCP) and the Indian health care provider has the capacity to provide primary care services to such Indian.

(10) 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.

(11) MCEs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. 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.

(12) MCE's shall honor requests made by other sources such as potential members, potential family members, or 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:

(a) MCEs shall address health literacy issues by preparing these documents 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);
(b) MCEs shall ensure that all staff who have contact with potential members are 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, which participating providers have bilingual capacity, which providers offices/facilities are accessible and have accommodations for people with physical disabilities, including offices, exam rooms, restrooms and equipment and are accepting new members.
(c) MCEs shall make written 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.
(d) MCE staff shall be able to provide potential members with information on how to access the Authority Beneficiary Support System, including for dual-eligible members 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

AMEND: 410-141-3300

RULE TITLE: Managed Care Entity (MCE) Member Education and Information Requirements

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Removal of definitions out of 410-141-3280 for placement in OAR 410-141-3000. Informational requirements and formatting requirements for potential members of all eligibility categories. Addition of Provider Directory requirements.

RULE TEXT:

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. The Authority shall approve prior to distribution 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) The creation of name recognition because of the MCE's health promotion or education activities may not constitute an attempt by the MCE to influence a client's enrollment.

(4) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(5) The following may not constitute marketing or an attempt by the MCE to influence client enrollment:

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

(b) Improving coordination of care;

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

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

(6) 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.

(7) 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 Exceptional Needs Care Coordination (ENCC) or 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 advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators, and 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.

(8) Written member education materials shall:

(a) Ensure 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;

(b) 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 and

the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;
(c) 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.
(9) Electronic versions of member materials, including provider directories, formularies, and handbooks shall be made available prominently on the MCE website 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, and the MCE shall provide it upon request within five business days.
(10) 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 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 information on accessibility of providers' offices, exam rooms, restrooms, and equipment.
(h) The provider directory must include 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 other 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.
(11) 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.
(12) 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.
(13) MCEs shall facilitate materials as follows:
(a) Translate the following written materials into the prevalent non-English languages served by the MCE:

(A) Welcome Packets that include welcome letters and member handbooks; and
(B) Notices of medical benefit changes.
(b) Information on disability access, alternate format and language statement inserts with:
(A) Communications regarding member enrollment; and
(B) Notice of Action Adverse Benefit Determination to deny, reduce, or stop a benefit, and Verification of Services Letter.
(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCE. Written and spoken language preferences are indicated on the Oregon Health Plan application form and reported to plans in 834 enrollment updates. MCEs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;
(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages and American Sign Language, not just prevalent non-English languages.
(14) 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.
(15) 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 other formats. Alternate formats may include but are not limited to readily accessible formatted materials, audio recordings, close-captioned videos, large (18 point) type, and braille;
(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 Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how members with the following special health care needs may access these care coordination services: Members who are aged, blind, disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;
(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 410-141-3230;
(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141- 3240.
(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;
(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.
(16) 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 his or her 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 Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how to access this care coordination through outreach to members 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 receive additional Authority Medicaid-funded long-term care or long-term services and supports;
(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.
(17) Informational materials that MCEs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English as previously outlined in this rule.
(18) 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

AMEND: 410-141-3420

RULE TITLE: Managed Care Entity (MCE) Billing

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Inclusion of Value-based Purchasing requirements. Removal of prior authorization from billing rule.

RULE TEXT:

(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;

(F) MCE's shall engage in collaborative efforts with the Authority to develop a Value-based Purchasing Roadmap.

(2) Providers shall be enrolled with the Division 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 Division 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 Division programs and;

(b) Whether the client is 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 contractor.

(7) MCEs shall pay for all covered capitated and coordinated care 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 time frames 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 410-141-3240.

(f) 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;
(g) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3240;
(h) MCEs may not require providers to delay billing to the MCE;
(i) 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;
(j) 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;
(k) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;
(L) 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.
(9) MCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or MCE's allowable for covered services the member receives within the MCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. MCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.
(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 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; and
(b) The ancillary covered service was delivered in good faith without the prior authorization; and
(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;
(d) 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 ORS 414.727;
(e) Except as specified in OAR 410-141-3140 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.
(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;
(g) 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.
(12) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):
(a) Sections (11)–(13) 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 410-141-3268 and 410-141-3269;
(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 section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.
(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 BBA 4712(b)(2).
(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 410-141-0500 Excluded Services and Limitations for OHP Clients.

STATUTORY/OTHER AUTHORITY: 413.042, 414.065, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.065, 414.610 - 414.685

AMEND: 410-141-3430

RULE TITLE: Coordinated Care Organization Encounter Claims Data Reporting

NOTICE FILED DATE: 11/08/2017

RULE SUMMARY: Inclusion of Coordination of Benefits Agreement (COBA) requirements.

RULE TEXT:

(1) CCOs 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 Division's 837 technical specifications for encounter data, and the Division's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site.

(2) CCOs must collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the CCO must utilize the HIPAA standards:

(a) CCOs shall submit encounter claims for all services, whether they are other health- related services or covered services, provided to members as defined in OAR 410-120-0000 and 410-141-3000.

(b) CCOs shall submit encounter claims data including encounters for services where the CCO determined that:

(A) Liability exists;

(B) No liability exists even if the CCO did not make any payment for a claim;

(C) Including claims for services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program; and

(D) Including paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the CCO, or the CCO's subcontractor.

(c) CCOs shall submit encounter claims data for all services to members who also have Medicare coverage, if a claim has been submitted to the CCO;

(d) Contractors 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);

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

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

(4) CCOs must submit encounter claims in the time frames as described below for the following claim types:

(a) Non-pharmacy encounter claims; professional, dental, and institutional:

(A) CCOs must submit encounter claims at least once per month for no less than 50 percent of all claim types received and adjudicated that month;

(B) CCOs must submit all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service except as may be applicable in paragraph (C) below;

(C) CCOs may only delay submission of encounter claims within 180 days from the date of service with prior notification to the Authority and only for any of the following reasons:

(i) Member's failure to give the provider necessary claim information;

(ii) Resolving local or out-of-area provider claims;

(iii) Third-Party Resource liability or Medicare coordination;

(iv) Member's pregnancy;

(v) Hardware or software modifications to CCO's health information system, or;

(vi) Authority recognized system issues preventing timely submission or correction of encounter claims data.

(b) Pharmacy claims:

(A) CCOs 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 http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization;

(B) All pharmacy encounter claims data must be submitted by the CCO whether by the CCO's pharmacy benefit manager or the CCO's subcontractor at least once a month for all services received and adjudicated that month and must submit all remaining unreported CCO pharmacy encounter claims within 60 days from the date of service.
(c) Submission Standards and Data Availability:
(A) CCOs must only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the CCO 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) CCOs must make an adjustment to any encounter claim when the CCO discovers 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 CCO 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 CCO must correct the errors within a time frame specified by the Authority;
(E) If circumstances prevent the CCO from meeting requested time frames for correction, the CCO may contact the Authority to determine an agreed upon specified date except as required in subsection (d) below;
(F) CCOs 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) CCOs must make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.
(d) Encounter Claims Data Corrections for "must correct" Encounter Claims:
(A) The Authority shall notify the CCO 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 CCO each week and for each subsequent week the encounter claim remains in a "must correct" status;
(C) The Authority may not necessarily notify the CCO of other errors; however, this information is available in the CCO's electronic remittance advice supplied by the Authority;
(D) CCOs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the CCO notice that the encounter claim remains in a "must correct" status.
(E) CCOs 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) Enrollment of providers included on an encounter claim:
(a) CCOs shall ensure that all providers are enrolled with the Authority prior to submission of the encounter claim as either:
(A) An Oregon Medicaid fee for service provider; or
(B) A provider that is not a fee for service provider but does provide services to the CCO's enrolled members.
(b) CCOs must ensure the provider is not excluded per federal and state standards as set forth in OAR 943-120-0100 through 943-120-0200 and as specified in 42 CFR 455.400 through 455.400.
(6) 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 CCO 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) CCOs must respond within the time frame determined by the Authority to any request for:
(A) Any suspected missing CCO encounter claims, or;
(B) CCO submitted encounter claims found to be unmatched to an EHR user's meaningful use report.
(7) CCOs 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) CCOs 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
(b) Immediately upon notification by the Authority that a qualifying encounter claim has been identified;
(c) The Authority in collaboration and cooperation with the CCO 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 CCO that no further action is needed;
(B) Requesting a corrected informed consent form, or;
(C) Informing the CCO 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 time frame set by the Authority.
(8) Upon request by the Authority, CCOs must furnish information regarding rebates for any covered outpatient drug provided by the CCO 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 CCO, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;
(b) CCOs shall report prescription drug data as specified in section (3)(b).
(9) 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 CCO for review and resolution within 15 days of receipt:
(a) The CCO shall assist in the dispute process as follows:
(A) By notifying the Authority that the CCO 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 CCO disagrees with the Invoiced Rebate Dispute that an error has been made, the CCO 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