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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: DCOs, CCO-F, New Dental Benefits, Orthodontia, Clarification And Removal Of Outdated Language

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RULES:
410-123-0010, 410-123-1060, 410-123-1260, 410-123-1490, 410-123-1540, 410-141-3500, 410-141-3515, 410-141-3525, 410-141-3585, 410-141-3705, 410-141-3720, 410-141-3800, 410-141-3805, 410-141-3810, 410-141-3840, 410-141-3865, 410-141-3875, 410-141-3885, 410-141-3890, 410-141-3920, 410-141-3960, 410-141-5015, 410-200-0315, 410-200-0445, 410-200-0450

AMEND: 410-123-0010

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Dental/Denturist Services

CHANGES TO RULE:

410-123-0010
Foreword
(1) The Oregon Health Plan offers Medicaid dental/denturist benefits on a fee-for-service (FFS) basis and through Managed Care Entities (MCE). These rules are Division rules ~~designed to assist~~to give fee-for-service providers direction in the delivery of dental services and in the preparation of dental care claims.¶
(2) Managed Care Entities (MCE) provide dental/denturist services under an approved contract with the Authority. In accordance with 42 CFR 438.210, MCEs are required to provide medic~~all M~~an~~aged Care Entitie~~d dental services in an amount, duration and scope. In accordance with 42 CFR 438.210, MCEs are required to provide medical and dental services ~~furnished~~ in an amount, duration and scope that ~~is no less than~~meets the minimum requirements for amount, duration and scope for the sam~~ount~~e services provided under FFS Medicaid., duration and scope for the same services provided under FFS Medicaid.¶
(a) MCEs~~:~~ must adhere to the Fee-for-Service Dental/Denturist Services rules in providing the minimum standard of care ~~allow~~require~~d~~ per federal regulations and within the MCE's contract. MCEs may provide services above and beyond these rules, according to each contract agreement, State Plan, and 1115 Waiver.¶
(b) For clients enrolled in an MCE, refer to the MCE rules and contracts for services rendered above and beyond the minimum standard found within the Fee-for-Service Dental/Denturist Services rules or guides. The MCE has the authority to provide more services than those found in these rules, as long as the amount, duration and scope is no less than the amount, duration and scope for the same services provided in these rules.¶
(c) The Fee-for-Service Dental/Denturist rules do not list every policy, procedure, and criteria for services. All

Division rules shall be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR ~~410 D~~chapter 410, division 120), and the Oregon Health Plan (OHP) Administrative Rules for Managed Care Entities (OAR chapter 410, division 141).
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1060

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Dental/Denturist Services

CHANGES TO RULE:

410-123-1060
Definition of Terms ¶

(1) "Abuse" has the meaning as provided in OAR 410-120-0000.¶
(2) "Acute" has the meaning as provided in OAR 410-120-0000.¶
(3) "Ambulatory Surgical Center (ASC)" has the meaning as provided in OAR 410-120-0000.¶
(4) "Anesthesia" refers to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026).¶
(5) "Anesthesia Services" has the same meaning as OAR 410-120-0000 and means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(6) "By Report (BR)" has the meaning as provided in OAR 410-120-0000.¶
(7) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure and nomenclature used by the American Dental Association.¶
(8) "Citizen~~/Alien-Waived Emergency~~ship Waived Medical" has the meaning as provided in OAR 410-120-0000. The acronym "C~~AWE~~WM" has the same meaning.¶
(9) "CMS-416" means the annual EPSDT participation report required by Section 1902(a)(43)(D) of the Social Security Act, which assesses the Oregon Health Plan's effectiveness in providing screening and dental services for EPSDT eligible children according to the appropriate periodicity schedule. For the purpose of the measurement, "Dental" services refer to services provided by or under the supervision of a dentist. "Oral health" services refer to services provided by a licensed practitioner that is not a dentist. For example, a pediatrician that applies a fluoride varnish, or an independently practicing dental hygienist not under the supervision of a dentist.¶
(10) "Covered Services" has the meaning as provided in OAR 410-120-0000.¶
(11) "COVID-19 Emergency" means the period:¶
(a) Starting on the earliest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. 247d, by the Governor of Oregon, or by the Authority; and¶
(b) Ending on the latest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. 247d, by the Governor of Oregon, or by the Authority.¶
(12) "Dental" means conditions having to do with the teeth and supporting structures.¶
(13) "Dental Care Organization" (DCO) ~~means a managed care entity that contracts, on a capitated basis, wit~~.¶
(14) "Dental Care Organization" (DCO) as provided for in ORS 414.025 (24) means a pre-paid managed care health services organization that provides, either by contract with a coordinated care organization or through othe~~r Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients~~r mechanisms, (i) dental services to the coordinated care organization's members, on a pre-paid capitated basis; or (ii) administrative services on behalf of the coordinated care organization as they relate to the delivery of dental services, including, without limitation: provider credentialing, prior authorization or denial of services, or encounter claims processing; or (iii) or both of the foregoing.¶
(1~~4~~5) "Dental Emergency Services" has the meaning as provided in OAR 410-120-0000. For the purpose of Division rules, Dental Emergency Services is synonymous with emergency dental care and emergency oral health care.¶
(1~~5~~6) "Dental Hygienist" has the meaning as provided in OAR 410-120-0000.¶
(1~~6~~7) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" has the meaning as provided in OAR 410-120-0000.¶
(1~~7~~8) "Dental Practitioner" means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.¶
(1~~8~~9) "Dental Services" has the meaning as provided in OAR 410-120-0000, and means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist or denture services provided within the scope of practice as defined under state law by a denturist or Expanded Practice Permit (EPP).¶
(~~19~~20) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes, administrative rules for client records and requirements of OAR 410-120 1360 Requirements for

Financial, Clinical and Other Records, and any other Documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(2~~0~~1) "Dental Emergency Condition" means any incident involving the teeth and gums which would require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed tooth:¶
(a) Emergency conditions are 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;¶
(b) The treatment of an emergency dental condition is limited only to Covered Services. The Division recognizes that some non-Covered Services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-Covered Service.¶
(2~~1~~2) "Dental Therapist" has the meaning provided in ORS 679.010.¶
(2~~2~~3) "Dentally Appropriate" has the meaning as provided in OAR 410-120-0000.¶
~~(23) "Dentally Necessary" has the meaning provided in OAR 410-120-0000.¶~~
(24) "Dentist" has the meaning as provided in OAR 410-120-0000.¶
(25) "Denturist" has the meaning as provided in OAR 410-120-0000.¶
(26) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.¶
(27) "Documentation" means dental services documentation which meets the requirements of the Oregon Dental Practice Act statutes, administrative rules for client records and requirements of OAR 410-120 1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(28) "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services" means the federally mandated comprehensive and preventative child health program for individuals under the age of 21, under the Omnibus Budget Reconciliation Act of 1989 and Section 1905(r)(5) of the Social Security Act. Consistent with state and federal law and regulations, the OHP Dental Program ensures that all dentally necessary services and screenings are provided, either directly or through an Authority contracted MCE for EPSDT covered services.¶
(29) "Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000.¶
(30) "Fraud" has the meaning as provided in OAR 410-120-0000.¶
(31) "Health Care Interpreter (HCI)" means an individual who has been approved and certified by the Authority under ORS 413.558 to accurately interpret oral statements and documents to a person with limited English proficiency or in sign language. Qualified Health Care Interpreter has the same meaning.¶
(32) "Health Systems Division" has the meaning as provided in OAR 410-120-0000, and is within the Authority. The Division is responsible for managing the Oregon Health Plan (OHP), which is Oregon's Medicaid program.¶
(33) "Hospital Dentistry" means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.¶
(34) "Interpreter Services" means services available to those with Limited English Proficiency (LEP) as described in Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; and ORS 413.550 for Meaningful Language Access Interpreter services may also be accessed for deaf or hard of hearing patients to ensure effective communication, as required by the Americans with Disabilities Act. The interpreter shall be a certified or qualified health care interpreter (HCI).¶
(35) "Managed Care Entity (MCE)" ~~has the meaning as provided in OAR 410-141-3500, and refers to~~is a general term that means an~~y~~ entity that enters into ~~a contract~~one or more contracts with the Authority to provide ~~covered~~ services in a managed care delivery system, including~~,~~ but not limited to~~, managed care organizations (MCO), prepaid~~ the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), ~~coordinated care organizations (CCO), and dental care organizations (DCO). Federal managed care rules and managed care model benefits may vary, depending upon federal requirements for MCEs, MCE contract requirements, and metric measures required by MCEs~~and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
(36) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.¶
(37) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.¶
(38) "Oral Health" means conditions of the lips, tongue, inner cheeks, soft and hard palate.¶
(39) "Oral Health Care" means services including, but not limited to, diagnostic, preventive, therapeutic, urgent, or emergency services provided by dental practitioners, dental specialists, dental hygienists, dental therapists, and trained primary care providers. In the dental field, oral health care and dental health care are used

synonymously.¶
(40) "Oral Health Services" means services provided by a non-dentist (such as primary care physicians and nurse practitioners) and not under a dentist's supervision.¶
(41) "Originating Site" means the site where the patient is located, and dental care providers are working and performing services in conjunction with a dentist who is not at that site, all while using telehealth technology.¶
(42) "Overpayment" has the meaning as provided in OAR 410-120-0000.¶
(43) "Physician" has the meaning as provided in OAR 410-120-0000.¶
(44) "Prepaid Ambulatory Health Plans" has the meaning provided in 42 CFR 438.2. The acronym "PAHP" has the same meaning.¶
(45) ~~"Prepaid Health Plan" and "PHP" each has the meaning as provided in OAR 410-120-0000.¶~~
~~(46)~~ "Primary Care Dentist (PCD)" as stated in OAR 410-120-0000, means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(4~~7~~6) "Primary Care Provider (PCP)" as stated in OAR 410-120-0000, 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.¶
(4~~8~~7) "Prior Authorization" has the meaning as provided in OAR 410-120-0000. The acronym "PA" has the same meaning.¶
(4~~9~~8) "Prioritized List of Health Services" (The List) means the comprehensive list of health services, ranked by priority, from the most important to the least important. The Oregon Health Plan benefits are made from The List and determined by the Oregon Legislature.¶
(~~50~~49) "Procedure Codes" means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.¶
(5~~1~~0) "Provider" has the meaning as provided in OAR 410-120-0000.¶
(5~~2~~1) "Referral" as stated in OAR 410-120-0000, 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.¶
(5~~3~~2) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances.¶
(5~~4~~3) "Teledentistry" means the modes specified in OAR 410-123-1265, using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information designed to improve a patient's health status and to enhance delivery of the health care services and clinical information.¶
(5~~5~~4) "Telehealth" means for the purposes of OAR 410-123-1265, OAR 410-120-1990 and as specified in ORS 679.543, a variety of methods using electronic and telecommunications technologies for the distance delivery of health care services, including dental care services and clinical information designed to improve a patient's health status and to enhance delivery of the health care services and clinical information.¶
(5~~6~~5) "Urgent Dental Care" means the management of conditions that require prompt attention to relieve pain and/or risk of infection and to alleviate the burden on hospital emergency departments. These should be treated as minimally invasively as possible. Urgent dental care is distinguished from emergency dental care in that, urgent dental care requires prompt but not immediate treatment. Examples include dull toothache, mildly swollen gums, or small chips or cracks in teeth. Members shall be seen or treated for Urgent Dental care within two weeks. Urgent care treatment is limited to covered services.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1260

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Specifies the details of the dental benefit coverage under the Oregon Health Plan (OHP). We are revising subsection 12, Orthodontics (D8000-D8999), of the rule. OHA is making minor changes to this rule to align with updated guidelines from the Health Evidence Review Commission (HERC) that will take effect 1/1/2023.

CHANGES TO RULE:

410-123-1260
OHP Dental Benefits ¶

(1) This administrative rule aligns with and reflects changes in relation to the American Dental Association (ADA) diagnosis and treatment pairs that are above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) found in OAR 410-141-3830 and not otherwise excluded under OAR 410-141-3825.¶
(2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):¶
(a) Medicaid-eligible participants from birth up through the day before their twenty-first birthday are eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This benefit covers age-appropriate screening visits and medically necessary Medicaid-covered services to treat identified physical, dental, developmental, and mental health conditions;¶
(b) Oregon's Medicaid and CHIP State Plans lists services covered under the OHP benefit package;¶
(c) For children over age one, Oregon's Medicaid 1115 Demonstration Waiver covers all EPSDT medically necessary services that are included on the prioritized list;¶
(d) Dental providers shall deliver EPSDT Dental Health Care screening visits and services at age-appropriate intervals following the "Oregon Health Plan (OHP) - Recommended Dental Periodicity Schedule," dated April 1, 2018, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx;¶
(e) Dental providers shall establish the delivery of routine preventive care services to children referred from primary care providers who deliver ~~Oral Health Care~~Dental screenings and fluoride varnish services in the medical setting;¶
(f) Prior Authorization and Referral requirements are imposed on medical and dental service Providers under EPSDT. Such requirements are designed as tools for determining a service, treatment or other measure meets the standards in subsection 2(c) of this section. The Authority determines which treatment to cover based upon the Provider's recommendations, current clinical guidance, and availability of equally effective alternative treatments;¶
(g) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 01, 1998. EPSDT services shall be medically or dentally necessary, and include, but are not limited to:¶
(A) Dental preventive screening services;¶
(B) Dental diagnosis and Dentally Necessary treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.¶
(3) ~~Oral Health~~Dental Services in Primary Care Settings - D0190 or D0191:¶
(a) Reimbursement is available to certified FFS and MCE Primary Care Providers who deliver a~~n or~~ dental evaluation, family ~~or~~dental health education, and topical application of fluoride varnish during EPSDT well-child periodicity scheduled visits:¶
(A) Assessment from a medical provider does not count toward the maximum number of services allowed by a dental provider;¶
(B) Medical providers may not delegate ~~or~~dental assessment to other staff members;¶
(C) The FQHC assessment encounter rate is inclusive of this service when performed during the medical or dental visit.¶
(b) For reimbursement in a medical setting, the performing provider shall meet all of the following criteria:¶
(A) Be a Physician (MD or DO), an advance practice nurse, or a licensed Physician assistant;¶
(B) Hold a certificate of completion from one of the following training programs within the previous three years:¶
(i) Smiles for Life;¶
(ii) or First Tooth.¶
(C) Perform ~~or~~dental health assessment/exam of infants and toddlers under six years of age during medical periodicity or inter-periodicity well-child exam. CDT Code D0190 or D0191 shall be used for the ~~Or~~Dental Health Care assessment portion of the well-child visit and may be used up to once per year for medical providers;¶

(D) Perform a caries risk assessment for children under six years of age using a standardized tool either:¶
(i) The First Tooth Tool developed by the Oregon Oral Health Coalition, or¶
(ii) a tool endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics.¶
(E) Make referral to a Dentist for FFS members or to the CCO member's assigned dental plan in order to establish a dental home with a primary care dentist. Preferably during the visit when an infant's first tooth erupts, commonly around six months of age. If patient has an established primary care dentist, refer the patient to their dental home for dental care;¶
(F) Provide anticipatory guidance and counseling with the client's caregiver on good ~~or~~dental hygiene practices and nutrition;¶
(G) Document in the medical chart risk assessment findings and service components provided.¶
(c) Topical fluoride treatment - D1206 or 99188:¶
(A) May be applied during any well-child visit for children under 19 years of age;¶
(B) If a medical provider delegates this procedure to a staff member, the staff member shall be trained on the application of fluoride varnish;¶
(C) Limited to two treatments yearly for children with low risk of tooth decay;¶
(D) Limited to four treatments yearly for children with high risk of tooth decay. Provider shall document visible decay and risk in patient chart;¶
(E) Fluoride treatment may be performed and billed during a separate well-child or preventative care visit from ~~or~~dental assessment;¶
(F) Use CDT code D1206 or CPT code 99188 and the appropriate ICD-10 fluoride administration code in the professional claim format as directed by the First Tooth or Smiles for Life program guide.¶
(G) CDT code D0190 is limited to use for mass screenings of children or non-dental professionals during EPSDT well-child and preventative care visits.¶
(d) Referrals:¶
(A) If, during the screening process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the client shall be referred to an appropriate provider for further diagnosis and/or treatment;¶
(B) The screening provider shall explain the need for the Referral to the client, client's parent, or guardian;¶
(C) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment should be offered;¶
(D) The child's FFS provider or the MCE program will also make available care coordination as needed.¶
(4) DIAGNOSTIC SERVICES (D0100 - D0999):¶
(a) Clinical ~~Or~~Dental evaluations (Exams):¶
(A) For children under 19 years of age:¶
(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:¶
(I) D0150: once every 12 months when performed by the same practitioner;¶
(II) D0150: twice every 12 months only when performed by different practitioners;¶
(III) D0180: once every 12 months.¶
(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner.¶
(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;¶
(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers shall not bill D0140 and D0170 for routine dental visits;¶
(D) The Division only covers ~~or~~dental exams performed by Medical Practitioners when the Medical Practitioner is an oral surgeon. The surgeon may hold a dual degree, but shall bill as an oral surgeon;¶
(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the Dentist. The Division may not reimburse dental exams when performed by a Dental Hygienist (with or without an expanded practice permit).¶
(b) Assessment of a patient (D0191):¶
(A) When performed by a Dental Practitioner, the Division shall reimburse:¶
(i) If performed by a Dentist outside of a dental office;¶
(ii) If performed by a Dental Hygienist with an expanded practice dental hygiene permit, or a licensed dental therapist;¶
(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a Patient (D0191) is included as part of an exam (D0120-D0180);¶

(iv) For children under 19 years of age, a maximum of twice every 12 months; and¶
(v) For adults age 19 and older, a maximum of once every 12 months.¶
(B) An assessment does not take the place of the need for ~~or~~dental evaluations/exams.¶
(c) Diagnostic imaging:¶
(A) The Division shall reimburse for routine imaging once every 12 months;¶
(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;¶
(i) D0240, D0250, D0251, D0273, D0274, D0277, D0321, D0322, D0701 - D0709 reimbursed once ever 12 months for all clients;¶
(ii) D0210, D0330 reimbursed once every five years, unless D0210 has been billed within the five-year period.¶
(C) The Division shall reimburse a maximum of six images for any one emergency;¶
(D) For clients under age six, images may be billed separately every 12 months as follows:¶
(i) D0220 - once;¶
(ii) D0230 - a maximum of five times;¶
(iii) D0270 - a maximum of twice, or D0272 once.¶
(E) The Division shall reimburse for panoramic radiographic image or intra-~~or~~dental complete series once every five years, but both cannot be done within the five-year period;¶
(F) Clients shall be a minimum of six years old for billing intra-~~or~~dental complete series. The minimum standards for reimbursement of intra-~~or~~dental complete series are:¶
(i) For clients age six through 11 - a minimum of ten periapicals and two bitewings for a total of 12 films;¶
(ii) For clients ages 12 and older - a minimum of ten periapicals and four bitewings for a total of 14 films.¶
(G) If fees for multiple single radiographs exceed the allowable reimbursement for a intraoral-complete series (full mouth), the Division shall reimburse for the complete series;¶
(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (refer to OAR 410-123-1060 and 410-120-0000);¶
(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;¶
(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting Documentation outlining the provider's attempts to receive previous records shall be included in the client's records;¶
(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.¶
(5) PREVENTIVE SERVICES (D1000-D1999):¶
(a) Dental prophylaxis:¶
(A) For children under 19 years of age - Limited to twice per 12 months;¶
(B) For adults 19 years of age and older - Limited to once per 12 months;¶
(C) Additional prophylaxis benefit provisions may be available for persons with high risk ~~or~~dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily ~~Or~~Dental Health Care.¶
(b) Topical fluoride treatment:¶
(A) For adults 19 years of age and older - Limited to once every 12 months;¶
(B) For children under 19 years of age - Limited to twice every 12 months;¶
(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or ~~or~~dental health factors are clearly documented in chart notes for clients who:¶
(i) Have high-risk ~~or~~dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant;¶
(iii) Have physical disabilities and cannot perform adequate, daily ~~Or~~Dental Health Care;¶
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily ~~Or~~Dental Health Care; or¶
(v) Are under seven years old with high-risk ~~or~~dental health factors, such as poor ~~or~~dental hygiene, deep pits, and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.¶
(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.¶
(c) Sealants:¶
(A) Are covered only for children under 16 years of age;¶
(B) The Division limits coverage to:¶
(i) Permanent molars; and¶
(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.¶
(d) Tobacco cessation:¶

(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following 5 step counseling is provided:¶
(i) ASK: Identify the patient's tobacco-use status at each visit and record information in the chart;¶
(ii) ADVISE: Using a strong personalized message, advise patients on their ~~or~~dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help; and¶
(iii) ASSESS: If the tobacco user is willing to make a quit attempt, refer patient to external resources or internal counseling and intervention protocol.¶
(iv) ASSIST: If dental provider chooses to assist, provide counseling and pharmacotherapy to help patient quit tobacco.¶
(v) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.¶
(B) The Division allows a maximum of ten services within a three-month period.¶
(e) Space maintenance (passive appliances):¶
(A) The Division shall cover fixed and removable space maintainers only for clients under 19 years of age;¶
(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.¶
(f) Interim caries arresting Medicament application (D1354/D1355): When used to represent silver diamine fluoride (SDF) applications for the treatment (rather than prevention) of caries, is limited to:¶
(A) Two applications per year;¶
(B) Requires that the tooth or teeth numbers be included on the claim;¶
(C) Shall be covered with topical application of fluoride when performed on the same date of service when treating a carious lesion;¶
(D) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354/D1355) on the same tooth, when Dentally Appropriate.¶
(g) Interim caries arresting Medicament application (D1354) is also included on The List to arrest or reverse noncavitated carious lesions. See The List Guideline Note 91 for more detail.¶
(6) RESTORATIVE SERVICES (D2000-D2999):¶
(a) Amalgam and resin-based composite restorations, direct:¶
(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;¶
(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;¶
(C) The Division limits payment for replacement of posterior composite restorations to once every five years;¶
(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;¶
(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);¶
(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶
(G) Interim therapeutic restoration on primary dentition is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) General payment policies:¶
(i) The fee for the crown includes payment for preparation of the gingival tissue;¶
(ii) The Division shall cover crowns only when:¶
(I) There is significant loss of clinical crown and no other restoration will restore function; and¶
(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures.¶
(iii) The Division shall cover core buildup only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure shall be remaining for coverage of the core buildup;¶
(iv) Reimbursement of retention pins is per tooth, not per pin.¶
(B) The Division shall not cover the following services:¶
(i) Endodontic therapy alone (with or without a post);¶
(ii) Aesthetics (cosmetics);¶
(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.¶

(C) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth;¶
(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:¶
(i) Prefabricated resin crowns are allowed only for anterior teeth, permanent or primary;¶
(ii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iii) Prefabricated post and core in addition to crowns;¶
(iv) Permanent crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752), and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if Dentally Appropriate;¶
(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed.¶
(III) Only for clients at least 16 years of age; and¶
(IV) Rampant caries are arrested, and the client demonstrates a period of ~~or~~dental hygiene before prosthetics are proposed.¶
(v) Porcelain fused to metal, and porcelain ceramic crowns shall also meet the following additional criteria:¶
(I) The Dental Practitioner has attempted all other Dentally Appropriate restoration options and documented failure of those options;¶
(II) Written Documentation in the client's chart indicates that PFM is the only restoration option that will restore function;¶
(III) The Dental Practitioner submits radiographs to the Division for review. History, diagnosis, and treatment plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);¶
(IV) The client has documented stable periodontal status with pocket depths within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, Documentation shall be maintained in the client's chart of the Dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;¶
(V) The crown has a favorable long-term prognosis; and¶
(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis.¶
(E) Crown replacement:¶
(i) Permanent crown replacement limited to once every seven years;¶
(ii) All other crown replacement limited to once every five years; and¶
(iii) The Division may make exceptions to crown replacement limitations due to Acute trauma, based on the following factors:¶
(I) Extent of crown damage;¶
(II) Extent of damage to other teeth or crowns;¶
(III) Extent of impaired mastication;¶
(IV) Tooth is restorable without other surgical procedures; and¶
(V) If loss of tooth would result in coverage of removable prosthetic.¶
(F) Crown repair is limited to only anterior teeth.¶
(7) ENDODONTIC SERVICES (D3000-D3999):¶
(a) Endodontic therapy:¶
(A) Pulpal therapy on primary teeth is covered only for clients under 21 years of age;¶
(B) For permanent teeth:¶
(i) Anterior and bicuspid endodontic therapy is covered for all OHP Plus clients; and¶
(ii) Molar endodontic therapy:¶
(I) For clients through age 20, is covered only for first and second molars; and¶
(II) For clients age 21 and older who are pregnant, is covered only for first molars.¶
(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.¶
(b) Endodontic retreatment and apicoectomy:¶
(A) The Division does not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;¶
(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:¶
(i) Crown-to-root ratio is 50:50 or better;¶
(ii) The tooth is restorable without other surgical procedures; or¶
(iii) If loss of tooth would result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or Dental Practitioner in the same

group practice completed the procedure;¶
(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;¶
(e) Apexification/recalcification procedures:¶
(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;¶
(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.¶
(8) PERIODONTIC SERVICES (D4000-D9999):¶
(a) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty - limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to ~~or~~dental hygiene procedures, e.g., Dilantin hyperplasia; and¶
(B) Includes six months routine postoperative care;¶
(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure.¶
(b) Non-surgical periodontal services:¶
(A) Periodontal scaling and root planing:¶
(i) Allowed once every two years;¶
(ii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;¶
(iii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(I) D4341 is allowed for quadrants with at least four or more teeth with pockets of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4341. The maximum number per quadrant and pocket depth requirements still apply;¶
(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4342. The maximum number per quadrant and pocket depth requirements still apply.¶
(iv) Prior Authorization for more frequent scaling and root planing may be requested when:¶
(I) Medically/Dentally Necessary due to periodontal disease as defined above is found during pregnancy; and¶
(II) Client's medical record is submitted that supports the need for increased scaling and root planing.¶
(B) Full mouth debridement allowed only once every two years.¶
(C) Scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after ~~or~~dental evaluation, allowed only once every two years.¶
(c) Periodontal maintenance allowed once every six months:¶
(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;¶
(B) Prior Authorization for more frequent periodontal maintenance may be requested when:¶
(i) Medically/Dentally Necessary, such as due to presence of periodontal disease during pregnancy; and¶
(ii) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;¶
(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:¶
(A) D1110 (Prophylaxis - adult);¶
(B) D1120 (Prophylaxis - child);¶
(C) D4210 (Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant);¶
(D) D4211 (Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant);¶
(E) D4341 (Periodontal scaling and root planning - four or more teeth per quadrant);¶
(F) D4342 (Periodontal scaling and root planning - one to three teeth per quadrant);¶
(G) D4346 (Scaling in presence of generalized moderate to severe inflammation, full mouth after ~~or~~dental evaluation);¶
(H) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and¶
(I) D4910 (Periodontal maintenance).¶
(9) PROSTHODONTICS, REMOVABLE (D5000-D5899):¶
(a) Clients age 16 years and older are eligible for removable resin base partial dentures and full dentures;¶
(b) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;¶
(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;¶

(d) Resin partial dentures:¶
(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;¶
(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;¶
(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with Documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;¶
(D) The Dental Practitioner shall note the teeth to be replaced and teeth to be clasped when requesting Prior Authorization (PA).¶
(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:¶
(A) For clients at least 16 years of age, the Division shall replace:¶
(i) Full dentures once every ten years, only if Dentally Appropriate;¶
(ii) Partial dentures once every five years, only if Dentally Appropriate.¶
(B) The five- and ten-year limitations apply to the client regardless of the client's OHP or ~~Dental Care Organization (DCO)/Coordinated Care Organization (CCO)~~MCE enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2020 and becomes a FFS OHP client in 2023. The client is not eligible for a replacement partial until February 1, 2025. The client gets a replacement partial on February 3, 2025 while FFS and a year later enrolls in a ~~DCO or CCO~~n MCE. The client would not be eligible for another partial until February 3, 2030, regardless of ~~DCO, CCO,~~MCE or FFS enrollment;¶
(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of Acute trauma, natural disaster, or catastrophic illness that directly or indirectly affects the ~~or~~dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily ~~or~~dental hygiene may not warrant replacement.¶
(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:¶
(A) A maximum of four times per year for:¶
(i) Adjustments to dentures, per arch. Full and partial (D5410 - D5422);¶
(ii) Replace missing or broken teeth - complete denture, each tooth (D5520);¶
(iii) Replace broken tooth on a partial denture - each tooth (D5640);¶
(iv) Add tooth to existing partial denture (D5650).¶
(B) A maximum of two times per year for:¶
(i) Repair broken complete denture base (D5511, D5512);¶
(ii) Repair resin partial denture base (D5611, D5612);¶
(iii) Repair cast partial framework (D5621, D5622);¶
(iv) Repair or replace broken retentive/clasping materials - per tooth (D5630);¶
(v) Add clasp to existing partial denture - per tooth (D5660).¶
(g) Replace all teeth and acrylic on cast metal framework (D5670, D5671):¶
(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;¶
(B) Ten years or more shall have passed since the original partial denture was delivered;¶
(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and¶
(D) Requires Prior Authorization as it is considered a replacement partial denture.¶
(h) Denture rebase procedures:¶
(A) The Division shall cover rebases only if a reline may not adequately solve the problem;¶
(B) For clients through age 20, the Division limits payment for rebase to once every three years;¶
(C) For clients age 21 and older:¶
(i) There shall be Documentation of a current reline that has been done and failed; and¶
(ii) The Division limits payment for rebase to once every five years.¶
(D) The Division may make exceptions to this limitation in cases of Acute trauma or catastrophic illness that directly or indirectly affects the ~~or~~dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily ~~or~~dental hygiene may not warrant rebasing;¶
(i) Denture reline procedures:¶

(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;¶
(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;¶
(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;¶
(D) Laboratory relines:¶
(i) Are not payable prior to six months after placement of an immediate denture;¶
(ii) For clients through age 20, are limited to once every three years;¶
(iii) For clients age 21 and older, are limited to once every five years.¶
(j) Interim partial dentures (also referred to as "flippers"):¶
(A) Are allowed if the client has one or more anterior teeth missing; and¶
(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when Dentally Appropriate.¶
(k) Tissue conditioning:¶
(A) Is allowed once per denture unit in conjunction with immediate dentures; and¶
(B) Is allowed once prior to new prosthetic placement.¶
(10) MAXILLOFACIAL PROSTHETIC SERVICES (D5900-D5999):¶
(a) Fluoride gel carrier is limited to those patients whose severity of ~~or~~dental disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The Dental Practitioner shall document failure of those options prior to use of the fluoride gel carrier;¶
(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to OAR 410-123-1220:¶
(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(B) For clients receiving services through a CCO, PHP, or MCE bill medical maxillofacial prosthetics to the CCO, PHP, or MCE;¶
(C) For clients receiving medical services through FFS, bill the Division.¶
(11) ORAL & MAXILLOFACIAL SURGERY (D7000-D7999): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(b) The Medical/Surgical Program is responsible for all ~~or~~dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures shall be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(c) D7285, D7286, D7287, D7288 diagnosis codes are reimbursable for all members;¶
(d) D7990 ancillary code is reimbursable for all members;¶
(e) All ancillary and diagnosis codes must be dentally necessary.¶
(f) Alveoloplasty not in conjunction with extractions are reimbursable for members under age 21, and for pregnant individuals (D7320, D73~~1~~21).¶
(12) ORTHODONTICS (D8000-D8999):¶
(a) Orthodontia services including for cosmetic purposes are not covered except as in (b) of this rule.¶
(b) The Division covers orthodontia services and extractions to treat craniofacial malocclusions, anomalies, cleft lip or cleft palate with cleft lip, and handicapping malocclusions when all of the following conditions are met:¶
(A) Using condition-treatment pair coding for craniofacial anomalies from the Prioritized List of Health Services;¶
(B) Following all corresponding Prioritized List Guideline Notes for treatment and care found on the Prioritized List treatment line;¶
(C) When treatment began prior to age 21, or surgical corrections for covered conditions were not completed prior to age 21; and¶
(D) ~~Significant malocclusion is expected to result in difficulty with mastification, speech, or o~~The Authority approves the request for fee-for-service coverage.¶
(c) Payment and prior authorization for CCO covered services is made by CCO's pursuant to the terms of their ~~oral functions; and¶~~
~~(E) The Authority approves the request for fee-~~contract with OHA, and the provisions of (a) and (b) if this section. Payment and prior authorization requirements in (c) through (k) of this section are for the "fee for- service ~~coverage~~" program.¶
(~~b~~d) PA is required for orthodontia ~~exams and records~~treatment;¶
(~~c~~e) Documentation in the client's record shall include diagnosis, length, and type of treatment;¶
(~~d~~f) Payment for appliance therapy includes the appliance and all follow-up visits;¶
(~~e~~g) Orthodontists evaluate orthodontia treatment for cleft palate, cleft lip, or cleft palate with cleft lip, cranial facial abnormalities, and dental-facial impairments as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall

reimburse each phase separately;¶
(~~f~~h) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;¶
(~~g~~i) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;¶
(~~h~~j) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;¶
(~~i~~k) Code:¶
(A) D8660 - PA required (reimbursement for required orthodontia records is included);¶
(B) Codes D8010-D8690 - PA required.¶
(13) ADJUNCTIVE GENERAL AND OTHER SERVICES (D9000-D9999):¶
(a) Fixed partial denture sectioning is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;¶
(b) Anesthesia:¶
(A) Only use general Anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure;¶
(B) The Division reimburses providers with a current permit to administer general Anesthesia or IV sedation as follows:¶
(i) D9223 or D9243: For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting;¶
(ii) Each 15-minute period represents a quantity of one. Enter this number in the quantity column.¶
(C) The Division reimburses administration of Nitrous Oxide per date of service, not by time;¶
(D) Non-intravenous conscious sedation:¶
(i) Limited to clients under 13 years of age;¶
(ii) Limited to four times per year;¶
(iii) Includes payment for monitoring and Nitrous Oxide; and¶
(iv) Requires use of multiple agents to receive payment.¶
(E) Upon request, providers shall submit a copy of their permit to administer Anesthesia, analgesia, and sedation to the Division;¶
(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those ~~or~~dental medications used during a procedure and is not intended for "take home" medication.¶
(c) The Division limits reimbursement of house/extended care facility call only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;¶
(d) ~~Or~~Dental devices/appliances (E0485, E0486):¶
(A) These may be placed or fabricated by a Dentist or oral-surgeon but are considered a medical service);¶
(B) Bill the Division, CCO, or the PHP, or MCE for these codes using the professional claim format.¶
(C) CDT code D9947 shall be billed on a dental claim form. See HERC Guideline Notes 27 and 36 for limitations.¶
(D) Adjustments for ~~or~~dental sleep apnea appliances (D9948) are considered normal follow-up care within the first 90 days after provision of the device, and is included as a bundled rate with D9947.¶
(E) ~~Or~~Dental sleep apnea repairs (D9949) are covered when necessary to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment shall be made for the excess.¶
(F) ~~Or~~Dental sleep apnea appliances (D9947) are replaceable at the end of their five year reasonable useful lifetime.¶
(14) Restorative, Periodontal, and Prosthetic Treatment Limitations:¶
(a) Documentation shall be included in the client's charts to support the treatment;¶
(b) Treatments shall be consistent with the prevailing standard of care and may be limited as follows:¶
(A) When prognosis is unfavorable;¶
(B) When treatment is impractical;¶
(C) A lesser cost procedure achieves the same ultimate result; or¶
(D) The treatment has specific limitations outlined in this rule.¶
(c) Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until rampant caries is arrested and a period of adequate ~~or~~dental hygiene and periodontal stability is demonstrated. Periodontal health needs to be stable and supportive of a prosthetic;¶
(d) Full and/or partial denture replacement. For indications and limitations of coverage and dental

appropriateness, the Division may cover reasonable and necessary replacement of dentally appropriate, covered full and/or partial dentures, including those items purchased or in use before the client enrolled with the Division:¶
(A) Replacement of full and/or partial dentures because of loss due to circumstances beyond the member's control, accident or natural disaster/ situations involving the provision of dentally appropriate items when:¶
(i) There is a change in the client's condition that warrants a new device;¶
(ii) The item is not repairable;¶
(iii) There is coverage for the specific item as identified in chapter 410, division 123;¶
(iv) Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.¶
(B) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of full and/or partial dentures may not be covered.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1490

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Dental/Denturist Services

CHANGES TO RULE:

410-123-1490
Hospital Dentistry
(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for (Division) clients who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-123-1060 for definitions.¶
(2) Division reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit:¶
(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;¶
(b) Refer to OAR 410-123-1220 for a definition of covered services.¶
(3) Hospital dentistry is intended for the following Division clients:¶
(a) Children (18 or younger) who:¶
(A) Through age three (3): Have extensive dental needs;¶
(B) Four (4) years of age or older: Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;¶
(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;¶
(D) Need the use of general anesthesia (or IV conscious sedation) to protect the developing psyche;¶
(E) Have sustained extensive orofacial or dental trauma;¶
(F) Have physical, mental or medically compromising conditions; or¶
(G) Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:¶
(i) Acute situational anxiety and extreme uncooperative behavior;¶
(ii) A physically compromising condition.¶
(b) Adults (19 or older) who:¶
(A) Have a developmental disability or other severe cognitive impairment, and one or more of the following characteristics that prevent routine dental care in an office setting:¶
(i) Acute situational anxiety and extreme uncooperative behavior;¶
(ii) A physically compromising condition.¶
(B) Have sustained extensive orofacial or dental trauma; or¶
(C) Are medically fragile, with a medical or physical condition which requires monitoring during dental procedures (i.e. coronary disease, asthma, or chronic obstructive pulmonary disease (COPD), heart failure, serious blood or bleeding disorder, or unstable diabetes or hypertension), have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client.¶
(4) Hospital dentistry is not intended for:¶
(a) Client convenience. Refer to OAR 410-120-1200;¶
(b) A healthy, cooperative client with minimal dental needs; or¶
(c) Medical contraindication to general anesthesia or IV conscious sedation.¶
(5) Required Documentation: The following information shall be included in the client's dental record:¶
(a) Informed consent: Client, parental or guardian written consent shall be obtained prior to the use of general anesthesia or IV conscious sedation;¶
(b) Justification for the use of general anesthesia or IV conscious sedation: The decision to use general anesthesia or IV conscious sedation shall take into consideration:¶
(A) Alternative behavior management modalities;¶
(B) Client's dental needs;¶
(C) Quality of dental care;¶
(D) Quantity of dental care;¶
(E) Client's emotional development;¶
(F) Client's physical considerations.¶
(c) If treatment in an office setting is not possible, Documentation in the client's dental record shall explain why, in the estimation of the dentist, the client will not be responsive to office treatment;¶

(d) The Division, or MCE may require additional Documentation when reviewing requests for prior authorization (PA) of hospital dentistry services. See OAR 410-123-1160 and section (6) of this rule for additional information;¶
(e) If the dentist did not proceed with a previous hospital dentistry plan approved by the Division for the same client, the Division will also require clinical Documentation explaining why the dentist did not complete the previous treatment plan.¶
(6) Hospital dentistry always requires prior authorization (PA) for the medical services provided by the facility:¶
(a) If a client is enrolled in an MCE with plan type CCOA:¶
(A) The dentist is responsible for:¶
(i) Contacting the MCE for PA requirements and arrangements; and¶
(ii) Submitting Documentation to ~~all~~the MCE~~s~~ associated with the client record.¶
(B) The ~~CCO or PHP and DCO~~MCE should review the Documentation and discuss any concerns they have, contacting the dentist as needed~~. This allows for mutual plan involvement and monitoring~~;¶
(C) The total response time should not exceed 14 calendar days from the date of submission of all required Documentation for routine dental care and should follow urgent~~/~~ or emergent dental care timelines;¶
~~(D) The CCO or PHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services.¶~~
(b) If a client is enrolled in a ~~Physician Care Organization (PCO) and a DCO:¶~~
~~(A) The PCO is responsible for payment of all facility and anesthesia services provided in an outpatient hospital setting or an ASC. The Division is responsible for payment of all facility and anesthesia services provided in an inpatient hospital setting. The DCO is responsible for payment of all dental professional services;~~n MCE with plan type CCOB:¶
(~~B~~A) The dentist is responsible for:¶
(i) Contacting the ~~PCO, if services are to be provided in an outpatient setting or an ASC, for PA requirements and arrangements; or¶~~
~~(ii) Contacting the Division, if services are to be provided in an inpatient setting~~MCE for PA requirements and arrangements; and¶
(iii) Submitting Documentation to ~~both the PCO (or the Division) and the DCO;¶~~
~~(C) The PCO or the Division and the DCO~~the MCE associated with the client record.¶
(B) The MCE should review the Documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan (CCO and FFS) involvement and monitoring;¶
(D) The ~~total~~MCE is respons~~e time should not exceed 14 calendar days from the date of submission of all required Documentation for routine dental care and should follow urgent/emergent dental care timelin~~ible for payment of all facility and anesthesia services. The fee-for-service (FFS) program is responsible for payment of all dental service~~s.~~;~~¶
(c) If a client is fee-for-service (FFS) for medical services and enrolled in a ~~D~~n MCE with plan type CCOG or CCO~~F~~E:¶
(A) The dentist is responsible for faxing Documentation and a completed American Dental Association (ADA) form to the Division. Refer to the Dental Services Provider Guide;¶
(B) If the client is assigned to a Primary Care Manager (PCM) through FFS medical, the client shall have a referral from the PCM prior to any hospital service being approved by the Division;¶
(C) The Division is responsible for payment of facility and anesthesia services. The ~~DCO~~MCE is responsible for payment of all dental ~~professional~~ services;¶
(D) The Division will issue a decision on PA requests within 30 days of receipt of the request.¶
(d) If a client is ~~enrolled in an MCE and is FFS dental:¶~~
~~(A) The dentist is responsible for contacting the MCE to obtain the PA and arrange for the hospital dentistry;¶~~
~~(B) The dentist is responsible for submitting required Documentation to the MCE;¶~~
~~(C) The MCE is responsible for all facility and anesthesia services. The Division is responsible for payment of all dental professional services.¶~~
~~(e) If a client is FFS for both medical and dental~~FFS for both medical and dental or enrolled in MCE plan type CCOE:¶
(A) The dentist is responsible for faxing Documentation and a completed ADA form to the Division. Refer to the Dental Services Provider Guide;¶
(B) The Division is responsible for payment of all facility, anesthesia services and dental ~~professional charges~~service.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1540

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Dental/Denturist Services

CHANGES TO RULE:

410-123-1540
Citizen~~/Alien-Waived Emergency~~ship Waived Medical (C~~AWE~~WM) ¶

(1) C~~AWEM cl~~WM recipients who are not pregnant (benefit package identifier CWM) have a limited benefit package. Dental coverage is limited to dental services provided in an emergency department hospital setting. Refer to OAR 410-1~~20-1210.¶~~
~~(2) CAWEM cl~~34-0003.¶
(2) CWM recipients who are pregnant (benefit package identifier CWX) receive the OHP Plus dental benefit package as described in OAR 410-1~~23-1260.¶~~
~~(3) All CAWEM clients are exempt from enrollment in a Dental Care Organization (DCO) or Coordinated Care Organization (CCO). Providers shall bill the Division directly for any allowable services provided~~34-0003.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-141-3500

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR chapter 410, division 141. The Authority also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.¶
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. For a final MCE claims decision, the date of "Adjudication" is the date on which an MCE has both (a) processed and (b) either paid or denied a Member's claim for services.¶
(3) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.¶
(4) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.¶
(5) "The Authority" means the Oregon Health Authority.¶
(6) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.¶
(7) "Auxiliary Aids and Services" means services available to members as defined in 45 CFR Part 92.¶
(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.¶
(11) "Capitated Services" means those covered services that an MCE agrees to provide for a capitation payment under contract with the Authority.¶
(12) "Capitation Payment" means monthly prepayment to an MCE for capitated services to MCE members.¶
(13) "Care Plan" means a documented plan that addresses the supportive, therapeutic, cultural, and linguistic health of a member. The member's care plan shall be developed for in collaboration with the Member and the Member's family or representative, and, if applicable, the Member's caregiver so that it incorporates their preferences and goals to ensure engagement and satisfaction. Care plans include, without limitation:¶
(a) Prioritized goals for a member's health;¶
(b) Identifying interventions and resources that will benefit and support the member's goals such as peer support, non-traditional services, community services, employment and housing support;¶
(c) Medication management; and¶
(d) Monitoring and re-evaluation.¶
(14) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.¶
(15) "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.¶
(16) "Client" means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE member.¶
(17) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.~~625~~572. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:¶
(a) In a Service Area where only one federally recognized tribe exists, the CCO shall seek one tribal representative to serve on the CAC;¶
(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one tribal representative from each tribe to serve on the CAC; and¶
(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian

Health Program for a representative to serve on the CAC.¶
(18) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.¶
(19) "Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.¶
(20) "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.¶
(21) "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~~572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.¶
(22) "Coordinated Care Services" mean an MCE's fully integrated physical health, behavioral health services, and ~~oral health~~dental services.¶
(23) "Corrective Action" or "Corrective Action Plan" means an Authority-initiated request for an MCE or an MCE-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.¶
(24) "Delivery System Network" means the entirety of those Participating Providers who (a) contracts with, or (b) are employed by, an MCE for purposes of providing services to the Members of such MCE. "Provider Network" has the same meaning.¶
(25) "Dental Care Organization (DCO)" ~~means a prepaid managed care health services organization that contracts, on a capitated basis, with the Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients. Dental Care Organization also meets the definition of a Prepaid Ambulatory Health Plan as defined under 42 CFR 438.2~~has the meaning as provided for in ORS 414.025 (24).¶
(26) "The Department" means the Department of Human Services.¶
(27) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.¶
(28) "Disenrollment" means the act of removing a member from enrollment with an MCE.¶
(29) "Diversity of the Workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.¶
(30) "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a M~~anaged Care Entity (MCE)~~CE that is subject to the requirements of ~~ORS~~42 CFR 438.242 and ~~ORS~~42 CFR 438.818.¶
(31) "Enrollment" means the assignment of a member to an MCE for management and coordination of health services.¶
(32) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:¶
(a) Annual exams;¶
(b) Contraceptive education and counseling to address reproductive health issues;¶
(c) Prescription contraceptives (such as birth control pills, patches or rings);¶
(d) IUDs and implantable contraceptives and the procedures requires to insert and remove them;¶
(e) Injectable hormonal contraceptives (such as Depo-Provera);¶
(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);¶
(g) Laboratory tests including appropriate infectious disease and cancer screening;¶
(h) Radiology services;¶
(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.¶
(33) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits.¶
(34) "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.¶
(35) "Grievance System" means the overall system that includes:¶
(a) Grievances to an MCE on matters other than adverse benefit determinations;¶

(b) Appeals to an MCE on adverse benefit determinations; and¶
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.¶
(36) "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.¶
(37) "Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.¶
(38) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP.¶
(39) "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, such as the practices of naturopathy or chiropractic and often involving nutritional measures.¶
(40) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency.¶
(41) "Indian" and/or "American Indian/Alaska Native (AI/AN)" 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; or as defined under 42 CFR 438.14(a).¶
(42) "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).¶
(43) "In Lieu of Service" (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).¶
(44) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.¶
(45) "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.¶
(46) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.¶
(47) "Legal Holiday" means the days described in ORS 187.010 and 187.020.¶
(48) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.¶
(49) "Managed Care Entity (MCE)" is a general term that means~~,~~ an entity that enters into ~~a contract~~one or more contracts with the Authority 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.¶~~
~~(50) "M~~the following types of entities defined in and subject to 42 CFR Part 438: managed ~~C~~care ~~O~~organizations (MCO~~)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Hs~~), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health ~~P~~plans (PIHPs). A~~n M~~ CCO is ~~responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by~~an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state ~~and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), or Physician Care Organization (PCO)~~funds or both.¶
¶
(50) "Managed Care Organization (MCO)" is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.¶
(51) "Material Change to Delivery System" means:¶
(a) Any change to the CCO's Delivery System Network (DSN) that may result in more than five (5) percent of its

~~M~~members changing the physical location(s) of where services are received; or¶
(b) Any change to CCO's DSN that would likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type; or¶
(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or¶
(d) Any combination of the above changes.¶
(52) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:¶
(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;¶
(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.¶
(53) "Member" means an OHP client enrolled with an MCE.¶
(54) "Member Representative" means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.¶
(55) "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.¶
(56) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.¶
(57) "Ombudsperson Services" means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.¶
(58) "Oral Health" means conditions of the mouth, teeth, and gums.¶
(59) "Oregon Health Plan (OHP)" means Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both.¶
(60) "Oregon Integrated and Coordinated Health Care Delivery System" means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.~~62~~2570.¶
(61) "Participating Provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(62) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.¶
(63) "Post-Hospital Extended Care Services" (PHECS). Consistent with 42 USC 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than 3 consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility:¶
(a) Within 30 days after discharge from such hospital~~,~~; or¶
(b) Within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and¶
(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.¶
(64) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.¶
(65) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:¶
(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;¶

(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000.¶
(66) "Provider" means an individual, facility, institution, corporate entity, or other organization that:¶
(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or¶
(b) Bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a Provider, (and also termed a "Billing Provider"); and¶
(c) Supplies health services or items (also termed a "Rendering Provider").¶
(67) "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.¶
(68) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.¶
(69) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:¶
(a) A child or youth, between the ages of birth to 21 years of age; and¶
(b) Must meet criteria for diagnosis, functional impairment and duration:¶
(A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):¶
(i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);¶
(ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).¶
(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;¶
(C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year.¶
(70) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either:¶
(a) Have functional disabilities;¶
(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or¶
(c) Are a Member of the Prioritized Populations as defined in OAR 410-141-3870.¶
(71) "Subcontract" means either:¶
(a) A contract between an MCE and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the MCE under its contract with the State; or¶
(b) Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.¶
(72) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.¶
(73) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.¶
(74) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to

the Home CCO service area.¶
(75) "Trauma-informed services" means those services provided using a Trauma Informed Approach.¶
(76) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.¶
(77) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.¶
(78) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.¶
(79) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. ~~A client whose oral health services are paid by the fee-for-service program may be enrolled in a dental care organization (DCO) directly contracted by the Authority if the client's residence is covered by the DCO's service area.~~ If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶
(a) CCOA: Physical~~, or~~ health, dental, and behavioral health services are paid by the client's CCO;¶
(b) CCOB: Physical and behavioral health services are paid by the client's CCO. ~~Oral health~~Dental services are paid by the fee-for-service program;¶
(c) CCOE: Behavioral health services are paid by the client's CCO. Physical ~~and oral health services are paid by the fee-for-service program;¶~~
~~(d~~health and dental services are paid by the fee-for-service program; ¶
(d) CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120;¶
(A) Any reference to CCOF means the benefit package covers that dental services only; and¶
(B) CCOG: ~~Or~~Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program~~;~~.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3515

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3515
Network Adequacy
(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate will become enrolled as members.¶
(2) The MCE shall develop a provider network that enables members to access services within the standards defined ~~below~~in this rule.¶
(3) The MCE shall meet access-to-care standards that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.¶
(4) MCEs shall meet quantitative network access standards defined in rule and contract.¶
(5) ~~CCO~~MCEs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.¶
(6) In developing its provider network, the ~~CCO~~MCEs shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health conditions, in the most appropriate and independent setting, including in their own home or independent supported living.¶
(7) All MCEs shall ensure ~~all~~95% of members can access providers within acceptable travel time or distance requirements. ~~Specifically:~~¶
(a) ~~CCO~~MCEs shall ensure all members can access the following provider and facility types within acceptable travel time or distance:¶
(A) Mental health providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(B) ~~Oral health~~Dental services providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(C) Specialty providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(D) Substance use disorder providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(E) Primary care providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(F) Patient Centered Primary Care Homes;¶
(G) Federally Qualified Health Centers;¶
(H) Hospital;¶
(I) Hospital, acute psychiatric care;¶
(J) Rural Health Centers;¶
(K) Pharmacies;¶
(L) Post-hospital skilled nursing facilities;¶
(M) Urgent Care Centers;¶
(N) Additional provider types when it promotes the objectives of the Authority.¶
(b) ~~DCOs directly contracted with the Authority must ensure all members have access to the following provider types within acceptable travel time and distance: denturist; expanded practice dental hygienists; dentofacial orthopedics; oral and maxillofacial pathologists; oral and maxillofacial surgeons; periodontists; orthodontists; endodontists; primary care dentists, adult; primary care dentists, pediatric; primary care dentist, both adult and pediatric, prosthodontics; registered dental hygienists; emergency dental services clinics; Federally Qualified Health Centers; Indian Health Services and Tribal Health Services; Public/County Health Departments; Rural Health Centers; and additional provider types when it promotes the objectives of the Authority.¶~~
~~(c)~~ All "MCEs" acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications. Time and distance standards may not exceed the following, unless otherwise approved by the Authority:¶
(A) In urban areas, 30 miles, or 30 minutes;¶
(B) In rural areas, 60 miles, or 60 minutes.¶
(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how

provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:¶
(a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;¶
(b) The number and types of providers required to furnish the contracted services and the number and types of providers actively providing services within the MCE's current provider network;¶
(c) How the MCE will meet the accommodation and language needs of individuals with LEP as defined in OAR 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;¶
(d) The availability of telemedicine within the MCE's contracted provider network.¶
(9) ~~CCO~~MCEs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.¶
(10) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or O~~YA~~regon Youth Authority (OYA) services have access to primary care, oral care (when the MCE ~~or DCO~~ is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. ~~Specifically,~~ MCEs shall monitor and have policies and procedures to ensure:¶
(a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;¶
(b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.¶
(11) ~~CCO~~MCEs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:¶
(a) Physical health:¶
(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;¶
(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;¶
(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.¶
(b) Oral and Dental care for children and non-pregnant individuals:¶
(A) Dental Emergency services as defined in OAR 410-120-0000: Seen or treated within 24 hours;¶
(B) Urgent dental l care: Within two weeks;¶
(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.¶
(c) Oral and Dental care for pregnant individuals:¶
(A) Dental Emergency services. Seen or treated within 24 hours;¶
(B) Urgent dental care, within one week;¶
(C) Routine oral care: Within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate.¶
(d) Behavioral health:¶
(A) Urgent behavioral health care for all populations: Within 24 hours;¶
(B) Specialty behavioral health care for priority populations:¶
(i) In accordance with the timeframes listed ~~below~~in this rule for assessment and entry, terms are defined in OAR 309-019-0105, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;¶
(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to

capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;¶
(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;¶
(iv) Opioid use disorder: Assessment and entry within 72 hours;¶
(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;¶
(vi) Children with serious emotional disturbance as defined in OAR 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.¶
(C) Routine behavioral health care for non-priority populations: Assessment within seven days of the request, with a second appointment occurring as clinically appropriate.¶
(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who have Limited English Proficiency, living in a household where there is no adult available to communicate in English or there is no telephone:¶
(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives;¶
(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical health, behavioral health, or ~~oral care (when the MCE or DCO is responsible for oral care)~~dental services visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members;¶
(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;¶
(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCEs shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language; and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;¶
(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;¶
(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;¶
(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:¶
(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;¶
(B) MCEs shall collect and report language access and interpreter services to the Authority quarterly using the report form provided by the Authority. The quarterly due date for each Report is the first day of each calendar quarter, reporting data for the twelve (12) months ending one quarter before the due date. The first such twelve-month Report is due by April 1, 2022, for the twelve-month period from January 1, 2021, through December 31, 2021;¶
(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.¶
(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. MCEs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.¶
(14) MCEs must submit a Delivery System Network (DSN) report annually to the Authority that includes access

data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:¶
(a) Behavioral health access;¶
(b) Interpreter utilization by the MCE's provider network;¶
(c) Behavioral health provider network.¶
(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).¶
(16) MCEs shall implement and require its providers to adhere to the following appointment and wait time requirements:¶
(a) A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;¶
(b) MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:¶
(A) Timely rescheduling of missed appointments, as deemed medically appropriate;¶
(B) Documentation in the clinical record or non-clinical record of missed appointments;¶
(C) Recall or notification efforts; and¶
(D) Method of member follow-up.¶
(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, MCEs shall provide outreach services as medically appropriate;¶
(d) Recognition of whether NEMT services were the cause of the member's missed appointment.¶
(17) ~~CCOs must contract with the following specific provider types:¶~~
~~(a) Providers of residential chemical dependency treatment services;¶~~
~~(b) Any oral care organizations necessary to provide adequate access to oral services in the area where members reside.¶~~
~~(18) CCO~~MCEs shall assess the needs of their membership and make available supported employment and Assertive Community Treatment services when members are referred and eligible:¶
(a) ~~CCO~~MCEs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by the Authority. When no appropriate provider is available, the MCE shall consult with the Authority and develop an approved plan to make supported employment and Assertive Community Treatment (ACT) services available;¶
(b) If 10 or more members in a ~~CCO~~MCE region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive ACT for more than 30 days, ~~CCO~~MCEs shall take action to reduce the waitlist and serve those individuals by:¶
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or¶
(B) Adding additional Assertive Community Treatment teams; or¶
(C) When no appropriate ACT provider is available, the ~~CCO~~MCE shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3525

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3525
Outcome and Quality Measures
Outcome and Quality Measures¶
(1) MCEs shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS.¶
(2) The MCE shall inform the Authority if it has been accredited by a private independent accrediting entity. If the MCE has been so accredited, the MCE shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review in accordance with CFR 42 CFR §438.332.¶
(3) As required by health system transformation, MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. Measures are selected by ~~OHA;~~the Authority with the incentive measures specifically adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at the Metrics and Scoring Committee website located at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx.¶
(4) MCEs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health care, ~~oral health care~~dental services , and all other health services provided by or under the responsibility of the MCE as specified in the MCE's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.¶
(5) MCEs shall implement an ongoing comprehensive quality assessment and performance improvement program (QAPI) for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the MCE's contract. This process shall include an internal Quality Improvement (QI) program with written criteria based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with the requirements set forth in 42 CFR §438.330, relevant law and the community standards for care, or in accordance with accepted medical practice, whichever is applicable, and with accepted professional standards. MCEs shall have in effect mechanisms to:¶
(a) Detect both underutilization and overutilization of services;¶
(b) Evaluate performance and customer satisfaction consistent with MCE contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);¶
(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3890 through 410-141-3915;¶
(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid funded long-term care or long-term services and supports benefits; or who are children receiving ~~CAF (~~ Child Welfare~~)~~ services or OYA services; and¶
(e) Report on the diversity and capacity of the workforce in their service area including capacity to provide services in a culturally responsive and trauma informed manner, ~~relying, as~~ appropriate~~,~~ly relying on workforce data provided by the Authority;¶
(f) Undertake performance improvement projects that are designed to improve the access, quality and utilization of services. Projects must be designed to achieve significant improvement in health outcomes and member satisfaction.¶
(6) MCEs shall implement policies and procedures that assure the timely collection of data including health disparities and other data required by rule or contract (or both) that allows the MCE to conduct and report on its outcome and quality measures and report its performance. MCEs shall submit to the Authority the MCE's annual written evaluation of outcome and quality measures established for the MCE or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee; including but not limited to output from Electronic Health Records, Chart Reviews, Claim validation reports and other materials required

for final assessment of relevant measures and within established deadlines.¶
(7) MCEs shall adopt practice guidelines consistent with 42 CFR 438.236 and the MCE contract that addresses assigned contractual responsibilities for physical health care, behavioral health care, or oral health careand/or dental services ; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3860; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.¶
(8) MCEs shall be accountable for both core and transformational measures of quality and outcomes:¶
(a) Core measures will be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts. Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) eCQMs or Electronic Clinical Quality Measures (eCQM) and Healthcare Effectiveness Data and Information Set (HEDIS) that have state or national normative statistics;¶
(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational measures may include culturally informed care, health equity or health-related services not typically associated with medical care. Transformational metrics will also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.¶
(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.464372 and 442.466373 and the MCE agreement in the manner authorized by OAR 409-025-0130.¶
(10) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. MCEs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The QI Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Authority members including those who are eligible for intensive care coordination (ICC) services under OAR 410-141-3870 or shall be able to retain consultation from individuals who are qualified.¶
(11) MCEs shall establish a QI Committee that shall meet at least every two months. The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:¶
(a) Approve the MCE annual quality strategy and retain oversight and accountability of quality efforts and activities performed by other MCE committees including the following: implementation of the annual quality strategy, a 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.;¶
(b) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process;, and review of results, progress, and effectiveness of corrective actions recommended at previous meetings. These records and minutes shall be made available to relevant OHAAuthority quality staff, upon request;¶
(c) MCEs shall conduct and submit to the Authority an annual written evaluation of the QI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the QAPI program and member care is to include an assessment of annual activities conducted which includes background and rationale, a plan of ongoing improvement activities to address gaps which will ensure quality of care for MCE members and overall effectiveness of the QI program. MCEs shall submit their evaluations to the Authority contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy as outlined in the MCE contract for the QAPI and transformational care annual evaluation criteria.;¶
(d) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant member complaints and appeals as required in OAR 410-141-3915;¶
(e) Review written procedures, protocols and criteria for member care no less than every two years, or more

frequently as needed to maintain currency with clinical guidelines and administrative principles.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3585

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3585
MCE Member Relations: Education and Information
(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE or its subcontractors and providers that:¶
(a) Is intended solely for members; and¶
(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.¶
(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.¶
(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's coordinated care model. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.¶
(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:¶
(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Intensive Care Coordination (ICC) Services, and where applicable for Full Benefit Dual Eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;¶
(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305 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;¶
(c) Inform all members of the availability of Ombudsperson services.¶
(5) Written member materials shall comply with the following language and access requirements:¶
(a) Materials shall be translated in the prevalent non-English languages as defined in OAR 410-141-3575 in the service area as well as include a tagline in large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;¶
(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings;¶
(c) Electronic versions of member materials shall be made available on the MCE website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the MCE shall provide it upon request within five business days.¶
(6) MCE provider directories shall be a single, comprehensive resource that encompasses the MCE's entire Provider Network, including any Providers contracted by Subcontractors that serve the MCE's Members. MCEs may not utilize a Subcontractor's separate or standalone provider directory to meet the Provider Directory requirement and shall include:¶

(a) The provider's name as well as any group affiliation;¶
(b) Street address(es);¶
(c) Telephone number(s);¶
(d) Website URL, as appropriate;¶
(e) Provider Specialty, as appropriate;¶
(f) Whether the provider will accept new members;¶
(g) Whether the provider offers both telehealth and in-person appointments;¶
(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;¶
(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶
(j) ~~Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in OAR 410-141-3735. Whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);~~Narrative space that is optional for providers to list biographical, cultural, linguistic, or other relevant information.¶
(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of provider~~s~~'s offices, exam rooms, restrooms, and equipment.¶
(L) 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.¶
(m) Information included in the provider directory shall be updated at least monthly, and electronic provider directories shall be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format.¶
(7) 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.¶
(8) Within 14 days 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.¶
(9) 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.¶
(10) 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 as defined in OAR 410-141-3575 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille;¶
(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;¶
(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.¶
(11) 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.¶
(12) MCE Member Handbooks shall comply with the Authority's formatting and readability standards and contain all elements outlined in the Member Handbook Evaluation Criteria issued by the Authority in accordance with the requirements described in Exhibit B, Part 3, Section 5 of the Contract. ¶
(13) 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 shall not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:¶
(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;¶
(B) Any information the member needs to decide among all relevant treatment options;¶
(C) The risks, benefits, and consequences of treatment or non-treatment.¶
(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;¶
(d) An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;¶
(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 Material Changes to Delivery System as defined in OAR 410-141-3500 or any other significant changes in provider(s), 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 within 15 calendar days after receipt or issuance of the termination notice 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.¶
(14) 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: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3705

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3705
Criteria for CCOs
(1) In administering the procurement process described in OAR 410-141-3700, the Authority shall require applicants to describe their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System, including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall develop an RFA that includes, at a minimum, the elements described in this rule:¶
(a) This rule lists legal requirements for CCOs, followed by corresponding application requirements that CCO applicants shall be required to address in the RFA;¶
(b) The Authority shall interpret the qualifications and expectations for CCO contracting within the context of the laws establishing health system transformation, as well as the Oregon Health Policy Board's adopted reports and policies;¶
(c) The Authority's evaluation of CCO applications shall account for the developmental nature of the CCO system:¶
(A) The Authority recognizes that CCOs and partner organizations need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System;¶
(B) An applicant who does not yet satisfy an RFA criterion must, at a minimum, have plans in place to meet the criterion. Unless otherwise specified in law or in the RFA, the Authority may use discretion in assessing whether the applicant is likely to make sufficient progress in implementing those plans to merit selection as a CCO candidate. Depending on the applicant's level of readiness, the Authority may consider invoking its authority under OAR 410-141-3700(4)(f) to deem an applicant "potentially eligible;"¶
(C) Contract provisions, including an approved Transformation and Quality Strategy (TQS) and work plan for implementing health services transformation, shall describe how the CCO will comply with transformation requirements under these rules throughout the term of the CCO contract to maintain compliance.¶
(2) Applicants shall describe their demonstrated experience and capacity for:¶
(a) Managing financial risk and establishing financial reserves;¶
(b) Meeting the following minimum financial requirements:¶
(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;¶
(B) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.¶
(c) Operating within a fixed global budget;¶
(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;¶
(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, ~~oral health care~~dental services , and covered long-term care services;¶
(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.¶
(3) Each CCO shall have a governance structure that meets the requirements of ORS 414.~~625~~572. The applicant shall:¶
(a) Clearly describe how it meets governance structure criteria from ORS 414.~~625~~572, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria are used to select governance structure members, and how it assures transparency in governance;¶
(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;¶
(c) Describe how its governance structure reflects the needs of members with serious and persistent mental illnesses and members receiving Medicaid-funded long-term care, services, and supports.¶
(4) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.~~625~~572. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.~~625~~572, how the CAC is administered to achieve the goals of community

involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.¶
(5) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:¶
(a) Since community health assessments evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before operating as a CCO;¶
(b) The applicant shall describe how it develops its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community needs that builds on community resources and skills and emphasizes innovation.¶
(6) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3730.¶
(7) 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.¶
(8) CCOs shall provide integrated, person-centered care and services designed to provide choice, independence, and dignity. The applicant shall describe its strategy:¶
(a) To assure that each member receives integrated, person-centered care and services designed to provide choice, independence, and dignity;¶
(b) For providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.¶
(9) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to certified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall describe:¶
(a) Planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, peer-delivered services specialists, personal health navigators, and qualified community health workers where appropriate;¶
(b) Planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.¶
(10) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:¶
(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;¶
(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.¶
(11) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:¶
(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all members;¶
(b) Be educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;¶
(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;¶
(d) Be permitted to participate in the networks of multiple CCOs;¶
(e) Include providers of specialty care;¶
(f) Be selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards;¶
(g) Establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in alignment with contractual requirements;¶
(h) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and mobile crisis services, Substance Use Disorder (SUD) service providers, and ~~oral health care when the CCO includes a dental care organization~~dental services, and facilitate

access to community social and support services including Medicaid-funded LTCSS, mental health crisis services, and culturally and linguistically appropriate services;¶
(i) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.¶
(12) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.¶
(13) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:¶
(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.~~625~~572 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.¶
(14) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting to include warm handoffs as appropriate based on requirements in OAR 309-032-0860 through 0870. Applicants shall:¶
(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;¶
(b) Demonstrate how hospitals and specialty services are accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;¶
(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.¶
(15) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, and Traditional Health Workers (THW). THWs include:¶
(a) Peer wellness specialists;¶
(b) Peer-support specialists;¶
(c) Personal health navigators;¶
(d) Family support specialist;-¶
(e) Youth support specialist;¶
(f) Doulas; and-¶
(g) Community health workers navigators.¶
(16) The applicant shall describe its planned policies for informing members about access to all types of THWs identified in OAR 410-180-0305.¶
(17) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:¶
(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;¶
(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;¶
(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long-term psychiatric care settings.¶
(18) CCOs shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with serious and persistent mental illness covered under the state's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:¶
(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;¶
(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.¶
(19) CCOs shall participate in the learning collaborative described in ORS 413.259. Applicants shall confirm their intent to participate.¶
(20) CCOs shall implement to the maximum extent feasible patient-centered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:¶

(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;¶
(b) The applicant shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.¶
(21) CCOs' health care services shall be culturally and linguistically appropriate and focus on achieving health equity and eliminating health disparities. The applicant shall describe its strategy for:¶
(a) Ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;¶
(b) Engaging in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;¶
(c) Collecting and maintaining race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards established by the Authority.¶
(22) CCOs are required to use alternative payment methodologies consistent with ORS 414.~~653~~598. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0125 and 409-025-0130. The applicant shall describe its plan to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.¶
(23) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe their:¶
(a) ~~Its i~~nitial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT Roadmap for meeting transformation expectations;¶
(b) ~~Its p~~Plan to support increased rates of electronic health record adoption among contracted providers, and to ensure that providers have access to health information exchange for care coordination;¶
(c) ~~Its p~~Plan to use HIT to make use of hospital event notifications and to administer value-based payment initiatives.¶
(24) CCOs shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the APAC data reporting system, and follow expectations for participation in annual TQS reporting to the Authority as detailed in the contract and external quality review with the Authority contracted External Quality Review Organization as outlined in 42 CFR ⍰⍰ 438.350, 438.358, and 438.364. The applicant shall provide the following assurances ~~that~~:¶
(a) ~~It has the c~~Capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;¶
(b) ~~It s~~Submit~~s~~, or ~~it~~ will submit, APAC data in a timely manner pursuant to OAR 409-025-0130.¶
(25) CCOs shall be transparent in reporting progress and outcomes. The applicant shall:¶
(a) Describe how it assures transparency in governance;¶
(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that are transparent and publicly reported and available on the Internet.¶
(26) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:¶
(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.~~625~~572;¶
(b) Whether the CCO uses a clinical advisory panel (CAP) or other means to ensure clinical best practices;¶
(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.¶
(27) CCOs shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:¶
(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Division of Financial Regulation on behalf of the Authority to confirm financial solvency and assess fiscal soundness;¶
(b) The applicant shall provide information relating to assets and financial and risk management capabilities.¶
(28) CCOs may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.¶
(29) CCOs shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the

medical assistance program.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3720

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3720
Service Area Change for Existing CCOs
(1) For purposes of this rule, the following definitions apply:¶
(a) "Applicant" means a coordinated care organization (CCO) as defined in ORS 414.~~625~~572 with a CCO contract with the Authority that submits an application seeking a contract amendment for a new service area. The CCO is described for purposes of this rule as the applicant upon its submission of the CCO Letter of Intent to Apply;¶
(b) "Document Review" means the review conducted by the Authority, occurring at the point after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant's ability to serve Medicaid beneficiaries in the requested service areas;¶
(c) "Letter of intent to apply (LOIA)" means a letter from a CCO to the Authority stating the CCO's intent to submit a SAC packet in response to a service area need. A LOIA may be binding or non-binding, as specified in the Authority's announcement of the service area need;¶
(d) "SAC packet" means the packet of application documents that the Authority provides to CCOs applying for a SAC;¶
(e) "Service Area Change" or "SAC" means a change in a CCO's service area as specified in the Authority's contract with the CCO;¶
(f) "Service Area Need" means when the Authority identifies a need, as defined in section (3) of this rule, for existing CCOs to apply to the Authority for a SAC to serve a service area.¶
(2) A CCO that desires to withdraw from all or a portion of its service area shall make every effort to provide the Authority with a form Letter of Intent to Exit the service area at least 150 calendar days prior to the intended date of withdrawal. The template for this form can be found on the CCO Contract Forms page. The Authority shall work with the CCO and any other impacted CCO for a workable exit transition.¶
(3) The Authority may determine a service area need exists, or is anticipated to exist, when a CCO would no longer be serving all or a portion of its service area.¶
(4) The Authority shall follow the process set forth in this rule when announcing a need for a SAC:¶
(a) Within 30 days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for the SAC. The announcement shall specify when the LOIA is due;¶
(b) Not later than 15 calendar days from the date of the Authority's notification in section (4)(a) ~~abov~~of this rule, the Authority shall issue a second announcement of the Authority's identification of a need for a SAC and when LOIAs are due;¶
(c) ~~T~~CCOs that want to be considered for a SAC~~, interested CCOs~~ shall submit their LOIAs by the deadline indicated in the Authority's notice of a need for a SAC. CCOs shall designate a sole point of contact in their LOIA for this process. The Authority will not accept a LOIA or any subsequent SAC application materials from a CCO that has not submitted a LOIA by the deadline indicated in the Authority's notice;¶
(d) The Authority shall send a letter of acknowledgement to the CCO within 10 calendar days of receipt of the LOIA.¶
(5) Within 30 calendar days of the date specified by the Authority as the due date for submission of a LOIA, the CCO shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC application packet. CCOs can locate a SAC packet on the CCO Contract Forms page.¶
(6) CCOs applying for the service area change process outlined in this rule must meet the requirements set forth in ORS 414.~~625~~572 and submit documentation as it applies to the new service areas indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3700 and 410-141-3705, shall be included in the acknowledgement letter sent by the Authority as described in section 4(d) of this rule, which shall include, but is not limited to, information related to the following:¶
(a) Delivery system network and provider capacity reports highlighting any providers operating in the new service area or existing contracted providers expanding their services into the new service area. This report would include providers of physical health, ~~oral health~~dental services , behavioral health, and non-emergent medical transportation. New relationships with ~~dental care organizations (DCOs) and~~ Non-Emergent Medical Transportation brokerages are to be included;¶
(b) Updated financial reports;¶
(c) Updated CCO governance organizational charts reflecting any changes due to new service area including CCO

leadership and managerial staffing, changes to Community Advisory Committee members, Clinical Advisory Panels membership, and any other committee or governance structure change as a result of operating in the new service area;¶
(d) Letters of community support from the community or communities in the new service area in which the CCO is applying to operate;¶
(e) List of specific new zip codes the CCO intends to serve and the estimated enrollment for each zip code area;¶
(f) Memorandums of understanding or letters of intent to enter into memorandums of understanding with local APD/AAA agencies, local mental health authority, local public health authority, and any other key stakeholders represented in the new service area;¶
(g) Updated Community Health Improvement Plan (CHP) reflecting new service area goals, if applicable;¶
(h) Updated Transformation Plan benchmarks or focus areas reflecting new service area goals, if applicable;¶
(i) Information related to how services in the new service area will impact existing operations including updated policies and procedures as applicable;¶
(j) Information related to identifying regional, cultural, socioeconomic, and racial disparities in health care that exist among the enrollees in the new service area and establishing community support for those areas of need; and¶
(k) Information related to coordination of care and transfer of new members, specifically high-risk members or members with special health care needs.¶
(7) The Authority shall review SAC packets from all CCOs that have timely submitted a LOIA and SAC packet as required by this rule and that are considered responsive and completed as set forth in this rule.¶
(8) During its review of the SAC packets, the Authority may request additional information from a CCO. If additional information is requested, the CCO shall submit the additional information to the Authority within 30 days of the request.¶
(9) Within 60 calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information. To be eligible for recertification in the new service area, the applicant must meet standards established by the Authority, this rule, and be in compliance with the contract between the CCO and the Authority.¶
(10) The Authority shall determine which CCO(s) will be selected to serve the new service area under the procedures and criteria set forth in OAR 410-141-3700(4) and 3705.¶
(11) The Authority shall prepare a contract amendment for document review and signature to each CCO that receives approval to expand into the new service area. The CCO shall have 60 calendar days to return an executed contract amendment for the service area change.¶
(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3550.
Statutory/Other Authority: ORS 413.042, 414.625, 414.645
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-3800

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3800
CCO Enrollment for Children Receiving Health Services
(1) Pursuant to OAR 410-141-3805, the Authority or Oregon Youth Authority (OYA) shall select CCOs for a child receiving services in an area where a CCO is available. ~~If a CCO is not available in an area, the Authority shall, to the extent feasible, enroll the child in an MHO in accordance with the procedures described in this rule; in such an event, the MHO is subject to the requirements described in this rule for CCOs.~~¶
(2) The Authority shall to the maximum extent possible ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority unless the Authority authorizes disenrollment from a CCO:¶
(a) Except as provided in OAR 410-141-3805 (Coordinated Care Enrollment Requirements), 410-141-3810 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO ~~or DCO~~ on the basis of third-party resources (TPR) coverage consistent with OAR 410-141-3805;¶
(b) The Authority shall review decisions to use fee-for-service (FFS) open card for a child if the child's circumstances change and, at the time of redetermination, shall consider whether the Authority shall enroll the child in a CCO.¶
(3) When a child is transferred from one CCO to another CCO or from FFS to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3860:¶
(a) CCOs shall work closely with the Authority to ensure continuous CCO enrollment for children;¶
(b) If the Authority determines that it should disenroll a child from a CCO, the CCO shall continue to provide health services until the Authority's established disenrollment date to provide for an adequate transition to the next CCO;¶
(4) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area:¶
(a) A temporary absence as a result of a temporary placement out of the CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to the CCO's service area at the end of the temporary placement;¶
(b) Children receiving children, adult, and family services from the Department who are eligible to be enrolled with the CCO serving the geographic area of placement: Department representatives may request a service area exc~~em~~ption (SAE) to maintain CCO coverage on a placement they consider temporary;¶
(c) Children in OYA custody who are eligible to be enrolled with the CCO serving the geographic area of placement: OYA representatives may request a service area exc~~em~~ption (SAE) to maintain CCO coverage on a placement they consider temporary.¶
(5) If the Authority enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall coordinate care and pay for covered health services during that placement even if the location of the facility is outside the CCO's service area:¶
(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment;¶
(b) Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO unless the provisions in OAR chapter 410, division 141 apply;¶
(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.¶
(6) Except for OAR 410-141-3805 and 410-141-3810, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3805

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3805
Mandatory MCE Enrollment Exceptions
(1) In addition to the definitions in OAR 410-120-0000, the following definitions apply:¶
(a) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;¶
(b) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;¶
(c) "Renewal" means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status;¶
(d) "Citizenship Waived Medical (CWM)" means any of the benefit packages described in OAR 410-134-0003.;¶
(e) ~~"Cover All Kids (CAK)" or~~ "HOP Child", "HOP non-pregnant Adult", and "HOP pregnant Adult" means the benefit packages described in OAR 410-134-0003;¶
(f) Compact of Free Association (COFA) Dental Program means the benefit package described in OAR 410-120-1210;¶
(g) Veteran Dental Program means the benefit package described in OAR 410-120-1210.¶
(2) CCO enrollment is mandatory in all areas served by a CCO. A client eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5), and this rule.¶
(3) MCE enrollment is mandatory in service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:¶
(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and ~~oral health services; or~~dental services, which is the CCOA plan type; ¶
(b) The member shall be enrolled with a CCO for physical health and behavioral health services and ~~with a DCO for oral health services; or~~shall remain fee-for-service (FFS) for dental services, which is the CCOB plan type; ¶
(c) The member shall be enrolled with a CCO for behavioral health and ~~oral health~~dental services and shall remain FFS for physical health services, which is the CCOG plan type; ~~or~~¶
(d) The member shall be enrolled with a CCO for behavioral health services and ~~with a DCO for or~~shall remain FFS for physical health services and ~~shall remain FFS for physical health services; or~~dental services, which is the CCOE plan type; ¶
(e) The member shall be enrolled with a ~~D~~CCO for ~~oral health~~dental services and ~~with an MHO for behavioral health services and~~remain FFS for physical health and behavioral health services, which is the CCOF plan type; ¶
(f) The member shall remain FFS for ~~physical~~ health care services if no MCE is available; or¶
(~~f~~g) ~~The member~~Members eligible for the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program benefit packages shall be enrolled ~~with~~in a ~~D~~CCO for ~~oral health services and remain FFS for physical health and behavioral heal~~dental services. Pharmacy services covered under th~~-~~ese~~rvices; or~~¶
~~(g) The member shall remain FFS for health care services if no MCE is available~~ benefit packages are Carve-Out Services paid by the Authority through the Oregon Prescription Drug Program.¶
(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.¶
(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.¶
(6) Members who are exempt from physical health services shall receive behavioral health services and ~~oral health~~dental services through an MCE:~~¶~~
~~(a).~~ The member shall ~~b~~:¶
(a) Be enrolled with a CCO that offers behavioral health and ~~oral health~~dental services; ~~or~~¶
(b) ~~The member shall b~~Be enrolled with a ~~D~~CCO for ~~oral health services and with an MHO for behavioral health services; or~~¶

~~(c) The member shall be enrolled with a DCO for oral health~~dental services and shall remain FFS for behavioral health services~~ if an MHO is not available~~; or¶
(~~d~~c) ~~The member shall r~~Remain FFS for both behavioral health and ~~oral health~~dental services if ~~neither a DCO nor an MHO is~~a CCO is not available.¶
(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:¶
(a) On or before Wednesday, the date of enrollment shall be the following Monday; or¶
(b) After Wednesday, the date of enrollment shall be one week from the following Monday.¶
(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:¶
(a) A newborn's ~~services~~enrollment shall begin on the date of birth if the mother was a member of a CCO and the newborn is OHP eligible at the time of birth;¶
(b) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.¶
(9) The following populations may not be enrolled into a~~ CCO or DCO or both~~n MCE, as indicated below in this rule, for any type of health care coverage or for the type of coverage specified:¶
(a) Individuals who are non-citizens and eligible for any of the CWM benefit packages described in OAR 410-134-0003, ~~including , but~~who are not eligible for ~~the CAK/~~OHP through the Healthier Oregon (HOP) Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package described in OAR 410-134-0003;¶
(b) Individuals eligible for ~~the CAK/HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package may not be enrolled into a DCO;¶~~
~~(c) Individuals eligible for~~OHP through the ~~CAK/~~HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package but for whom the Authority has not provided capitation or other payment rates in the applicable CCO contract;¶
(~~d~~c) Clients with Medicare receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without another Medicaid;¶
(~~e~~d) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).~~:~~;¶
(10) Individuals currently enrolled with an Indian Managed Care Entity (IMCE) consistent with OAR 410-146-5000 may not also be enrolled in the CCOA or CCOB plan type.¶
(11) If enrollment action coincides with an individual's Continuous Inpatient Stay as defined in OAR 410-141-3500, the following enrollment rules apply:¶
(a) A newly eligible OHP client who became eligible while admitted as an inpatient is exempt from ~~enrollment with a CCO for physical health and behavioral health services, but not~~all levels of CCO enrollment, exc~~em~~pt f~~rom MCE~~or newborn enrollment~~ oral health servi~~s in accordanc~~es~~ with ~~a DCO. The~~OAR 410-141-3805(8)(a). The newly eligible OHP client shall receive health care services on a Fee-For-Service (FFS) basis until the individual is discharged from the continuous inpatient stay;¶
(b) In settings where the CCO is fully responsible for covered services, such as an acute care hospital, acute care psychiatric hospital, skilled nursing facility specific to the Post-Hospital Extended Care (PHEC) benefit, Psychiatric Residential Treatment Facility (PRTF), or a residential Behavioral Health or Substance Use Disorder treatment facility that is not considered a Home and Community-Based Services (HCBS) setting as described in OAR 410-173-0035:¶
(A) The CCO is responsible for covered services if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made~~ (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO)~~ until the member is discharged from their continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment will be cancelled as never effective and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion;¶
(C) When a justice-involved individual, meeting the definition for Inmate stated within OAR 410-200-0015, is admitted to an inpatient setting with an expected stay of at least 24 hours, the individual temporarily resumes OHP eligibility and the inpatient stay is covered by FFS; CCO enrollment shall be the next available enrollment date following release from the penal facility as consistent with OAR 410-200-0140, OAR 461-135-0950, and OAR 410-141-3810, and based on the service area of the member's current permanent residence.¶
(c) In settings where the CCO is responsible for care coordination but not health services, including, but not limited to Medicaid-Funded Long Term Services and Supports (LTSS) or Behavioral Health Carve-Out Services:¶
(A) Contractor is responsible for care coordination if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the

member is discharged from their continuous inpatient stay to ensure continuity of care coordination;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment will be cancelled as never effective, and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care coordination;¶
(C) When a resident of a public institution, as defined in OAR 461-135-0950, is voluntarily or involuntarily admitted to the Oregon State Hospital, OHP eligibility is suspended and any associated CCO enrollment is ended with an effective date of the inpatient admission; however, the CCO is responsible for care coordination.¶
(d) If an individual is currently experiencing an extended but temporary hold within an Emergency Department due to unavailability of inpatient placement or delay in secure transportation to a facility that can evaluate appropriate psychiatric referrals, no enrollment changes shall be made (CCO-to-FFS or CCO-to-CCO) until the individual is no longer in the Emergency Department or, if subsequent action is admission to an inpatient setting, until the individual is discharged from their continuous inpatient stay.¶
(11~~2~~) A client may not be enrolled with a CCO in the CCOA, CCOB, CCOE, or CCOG plan type if the client is covered under a major medical insurance policy, Third Party Liability (TPL), or other Third-Party Resource (TPR) that covers the cost of services to be provided by a CCO as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800:¶
(a) A client shall be enrolled with a ~~DCO for oral health~~CCO in the CCOF plan type for dental services even if they have a dental TPR;¶
(b) At the Authority's discretion, a client shall be enrolled with the highest level of CCO coverage, including physical health, behavioral health, and ~~oral health~~dental services, if coverage through the TPR poses a safety risk to the member, specific to Good Cause determination as described in OAR 461-120-0350(1) and OAR 410-200-0220(6). In these situations:¶
(A) Recovery of third-party insurance should not be pursued; and¶
(B) Explanation of Benefits (EOB) should be suppressed.¶
(12~~3~~) Individuals who are ~~documented~~ American Indian and Alaskan Native (AI/AN) beneficiaries per 410-141-3500(41) are exempt from mandatory enrollment into an MCE, ~~as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.~~except for IMCE enrollment per 410-146-5000. ¶
(13~~4~~) A child in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and ~~oral health~~dental services as available in the member's service area unless:¶
(a) Access to health care on an FFS basis is not available; or¶
(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.¶
(14~~5~~) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:¶
(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;¶
(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise, the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;¶
(c) A full Medicare and Medicaid dually eligible member may request to opt out of enrollment for physical health services from a CCO~~,~~ but is subject to mandatory enrollment into both behavioral and ~~oral health~~dental services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:¶
(A) Access to health care on an FFS basis is not available; or¶
(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;¶
(i) The development of a prior-authorized treatment plan;¶
(ii) Care management requirements based on the beneficiary's medical condition;¶
(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and¶
(iv) Need for individual case conferences to ensure a "warm hand-off."¶
(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:¶

(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;¶
(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;¶
(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.¶
(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;¶
(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.¶
(15~~5~~6) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:¶
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;¶
(b) The following apply to clients and exemptions relating to organ transplants:¶
(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;¶
(B) Newly eligible clients with existing transplants are not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care.¶
(16~~6~~7) MCE enrollment standards:¶
(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:¶
(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;¶
(B) Closed enrollment as a sanction for MCE misconduct.¶
(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;¶
(c) MCEs may confirm the enrollment status of a client by one of the following:¶
(A) The individual's name appears on the monthly or weekly enrollment list produced by the Authority;¶
(B) The individual presents a valid medical care identification that shows they are enrolled with the MCE;¶
(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the MCE;¶
(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the MCE.¶
(d) MCEs shall have open enrollment for 30 continuous calendar days during each 12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.¶
(17~~7~~8) If the Authority permits an MCE to assign its contract to another MCE, members shall be automatically enrolled in the MCE that has assumed the contract:¶
(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the MCE that has assumed the contract;¶
(b) If the MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.¶
(18~~8~~9) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area such that the MCE cannot meet the access to care requirements set forth in OAR 410-141-3515 and which necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:¶
(a) An MCE may provide less than the required 90-calendar-day notice to the Authority upon approval by the Authority when the MCE must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the MCE and refuses to provide the required 90-calendar-day notice;¶
(b) The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority shall instead notify members of a change in participating providers or MCEs. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3810

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3810
Disenrollment from MCEs
(1) Member-initiated requests for disenrollment.¶
(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule;¶
(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:¶
(A) Without cause:¶
(i) Members may request to change their MCE enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle;¶
(ii) Members may request to change their MCE enrollment within 90 calendar days of the initial MCE enrollment. If approved, the change would occur during the next weekly enrollment cycle;¶
(iii) Members may request to change their MCE enrollment after they have been enrolled with ~~a plan~~the MCE for at least six months. If approved, the change would occur at the end of the month;¶
(iv) Members may request to change their MCE enrollment at their OHP eligibility renewal. If approved, the change would occur at the end of the month;¶
(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. If a request for disenrollment is approved under this section, the change would occur at the end of the month.¶
(B) With cause, at any time as follows:¶
(i) The member moves out of the MCE service area; or¶
(ii) Due to moral or religious objections the ~~CCO~~MCE does not cover the service the member seeks;¶
(iii) When the member needs related services (for example a Caesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.¶
(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to FFS at any time subject to the provisions set forth in OAR 410-141-3805(14)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition;¶
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include but are not limited to:¶
(i) The member is an American Indian or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the FFS delivery system;¶
(ii) The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member for a provider of a treatment, service, or supply:¶
(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary ~~CCO~~MCE exemption;¶
(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the member's administrative hearing rights;¶
(E) If 30 calendar days pass without a decision from the Authority on a member's disenrollment request, the

request becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).¶
(c) A member may request a temporary enrollment exception during pregnancy as follows:¶
(A) A temporary enrollment request will be granted if a member is at any point in the third trimester of pregnancy and:¶
(i) The member is newly determined eligible for OHP; or¶
(ii) The member is newly re-determined eligible for OHP and not enrolled in a ~~CCO~~MCE within the past three months; or¶
(iii) The member is enrolled with a new ~~CCO~~ MCE that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider.¶
(B) The enrollment exemption shall remain in place until 60 calendar days postdate of either the delivery of the member's child or the pregnancy otherwise ends, at which time the member shall be enrolled in the appropriate ~~CCO~~MCE in their service area. Where there is a choice among multiple ~~CCO~~MCEs in the member's service area they may choose an open plan; however, if the member does not express a preference to OHP, OHP will auto assign on a next weekly basis.¶
(d) Upon approval of a member's disenrollment from a ~~CCO~~MCE, the member shall join another ~~CCO~~MCE unless:¶
(A) The member resides in a service area where enrollment is voluntary; ~~or~~¶
(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805; ~~or~~¶
(C) The member meets disenrollment criteria stated in this rule; or¶
(D) There is not another ~~CCO~~MCE available and open to new enrollment in the service area.¶
(2) MCE-initiated disenrollment requests: MCEs may request disenrollment for any of the reasons ~~set forth below in this subsection (a)~~in subsection (2)(a) of this rule. Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified in this subsection (~~a) below~~2)(a) of this rule. After review of all necessary documentation submitted with an MCE's request, the Authority will grant such requests, except the Authority may deny requests based on the reason set forth in subparagraph (G) below:¶
(a) If the individual is enrolled after the first day of admission to an inpatient setting, the enrollment will be cancelled as never effective and the individual shall be enrolled in a ~~CCO~~MCE on the next available enrollment date following discharge from the continuous inpatient stay. This does not apply if the member is a newborn child born to an OHP eligible mother enrolled with a ~~CCO~~MCE at time of birth in accordance with OARs 410-141-3500 and 410-141-3805;¶
(b) If the ~~CCO~~MCE determines the member has Third Party Liability (TPL), the ~~CCO~~MCE shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The ~~CCO~~MCE shall receive an emailed tracking number following the online report. The ~~CCO~~MCE may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, ~~HIG~~the member shall be disenroll~~the membered~~ from the ~~CCO~~MCE effective at the end of the month the TPL is reported, with the exception of:¶
(A) When Good Cause determination is active or concurrently documented, in which case the member will retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(B) Some situations in which the Authority may approve retroactive disenrollment;¶
(C) When the client has dental TPR and is enrolled in the CCOF plan type.¶
(c) If a member has been residing outside the MCE's service area for more than three months unless previously arranged with the MCE. The MCE shall provide written documentation that the member has been residing outside its service area for more than three months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR will notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;¶
(d) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal facility. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;¶
(e) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution;¶
(f) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time

of enrollment in the MCE;¶
(g) The member had End Stage Renal Disease at the time of enrollment in the MCE.¶
(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.¶
(a) MCEs have the right to request the Authority disenroll members when they commit fraudulent or illegal acts related to participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts;¶
(b) The MCE shall report any illegal acts to law enforcement authorities and, if appropriate, to the DHS Fraud Investigations Unit;¶
(c) When requesting disenrollment based on a member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, including any verification of reports submitted to law enforcement and, if applicable, the DHS Fraud Investigations Unit;¶
(d) Based on the evidence presented, the CCO AR will review the disenrollment request and all submitted evidence with Authority staff. The review process will be documented and a recommendation for disenrollment will be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.¶
(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.¶
(a) Subject to applicable disability discrimination laws and ~~this sub~~section (4) of this rule, the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule;¶
(b) For purposes of this rule, a "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the MCE shall make an individualized assessment based on reasonable judgment that relies on~~c~~:¶
(A) Current medical knowledge or the best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; ~~t~~¶
(B) The probability that potential injury to others shall actually occur; and ~~w~~¶
(C) Whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others~~;~~.¶
(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:¶
(A) Physical, intellectual, developmental, or mental disability; or¶
(B) An adverse change in the member's health; or¶
(C) Under or over-utilization of services; or¶
(D) Filing a grievance or exercising any appeal or contested case hearing rights; or¶
(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or¶
(F) Uncooperative or disruptive behavior resulting from the member's special needs.¶
(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member. The provider shall document the written notification to the MCE in the member's medical record;¶
(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:¶
(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider. The MCE shall document the education, training, and the resources or services furnished to the reporting provider;¶
(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:¶
(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;¶
(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and¶
(iii) Inform the member that their continued behavior may result in disenrollment from the MCE.¶
(C) In the event the interventions undertaken in accordance with subsections (4)(e)(B) of this rule do not ameliorate the member's uncooperative or disruptive behavior, the MCE shall Contact the member's care team,

or develop a member focused care team if one does not already exist, to support the member in remediating their behavior. If needed, and with the consent of the member, the care team shall involve other appropriate individuals working with the member in the resolution within the laws governing confidentiality. The MCE shall facilitate cross functional care conferences that include the member, member focused care team, and other individuals chosen by the member with appropriate releases documented;¶
(D) In the event the member's uncooperative or disruptive behavior continues after undertaking the efforts identified in subsections (4)(e)(C) of this rule, the MCE shall convene an interdisciplinary team that includes a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior, their behavioral history, and previous efforts undertaken to manage the member's behavior, including those developed through the members care team and care conferences, in order to determine whether the member may be able to remediate their uncooperative or disruptive behavior through other reasonable clinical or social interventions.¶
(f) All efforts undertaken in connection with this section (4) of the rule, including, without limitation, all interventions, written and oral communications, training and education provided to the member and the member's provider(s), as well as those persons who participated in any and all interventions, care teams, assessments and the like, shall be documented in the member's MCE case file and as applicable, the provider shall document all efforts undertaken in the member's medical record;¶
(g) If, after undertaking all efforts identified in subsection (e) of this rule, the member's disruptive or uncooperative behavior cannot be managed sufficiently in order for a provider to provide the services the member requires, the MCE may submit to its CCO AR on MCE letterhead a written request for disenrollment that complies with all of the following:¶
(A) Sets forth the reasons for the request for disenrollment, details the attempts at intervention and accommodations that were made, why those interventions and accommodations were not effective, and includes all written documentation required under subsection (4)(f) of this rule;¶
(B) Identifies, and provides documentation in support of the identification of, any special health care needs or disability the disruptive or uncooperative member may have and describes:¶
(i) The relationship the uncooperative or disruptive behavior may have, if any, to the member's special health care needs or disability, which must be substantiated by a provider with the appropriate credentials and expertise in the member's special health care needs or disability; and¶
(ii) Why the MCE has concluded the member's disruptive or uncooperative behavior is not a consequence of the member's special health care needs or disability.¶
(C) States whether the member's uncooperative or disruptive behavior poses a direct threat to the health or safety of others;¶
(D) Identifies the documentation that supports the MCE's rationale for concluding that the member's continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either the member who has engaged in the uncooperative or disruptive behavior or the MCE's other members;¶
(E) Provides written documentation of CMS' approval for disenrollment of the member when the member is also enrolled in the CCO's Medicare Advantage plan;¶
(F) Furnishes all other information and documentation requested by the MCE's CCO AR.¶
(h) If a Primary Care Provider (PCP) terminates the provider/patient relationship during the period of time the CCO is undertaking the efforts described in section (4) of this rule, the CCO shall, prior to submitting a request for disenrollment, attempt to locate another participating PCP who will accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new PCP to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be consistent with the CCO's OHP policies, the CCO or PCP's policies for commercial members, and applicable disability discrimination laws.¶
(5) MCE Disenrollment Requests: Credible Threats of Violence.¶
(a) MCEs have the right to request an exception to the MCE initiated disenrollment requirements outlined in section (4) of this rule when a member has committed an act of, or made a credible threat of, physical violence directed at a health care provider, the provider's staff, other patients, or the MCE staff, so that it seriously impairs the MCE's ability to furnish services to either this particular member or other members;¶
(b) For purposes of this rule, a "credible threat" means that there is a significant risk that the member may cause grievous physical injury (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures;¶
(c) MCEs shall require their providers to notify both the MCE and law enforcement immediately when a member has acted violently or makes a credible threat of physical violence:¶
(A) The notification may be made to the MCE by telephone provided that such notice is followed by written notice to the MCE;¶
(B) Notice under subsection (5)(c) of this rule shall describe the circumstances surrounding the act or credible

threat of violence and the actions taken by the provider as a result;¶
(C) MCEs shall require their providers to document the incident in the member's medical record and the MCE shall document the provider's notice in the member's case file.¶
(d) The MCE shall notify the member's care team of the act or credible threat of violence. The MCE shall involve the member's care team and, within the laws governing confidentiality, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior;¶
(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence;¶
(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes ~~set forth~~listed in section (4) of this rule prior to making any request for disenrollment;¶
(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (5)(d) of this rule, by following the process set forth in section (4) of this rule, the MCE shall have the right to request the member's disenrollment. The MCE's disenrollment request shall comply with all of the requirements set forth in section (4)(g) of this rule and shall also comply with all additional requirements as follows:¶
(A) Include an explanation of why the MCE believes the exception to following the process ~~set forth~~explained in section (4) of this rule is necessary as it relates to an act of, or credible threat of, physical violence; and¶
(B) In addition to all other documentation required to be submitted under section (4) of this rule, the request must also include a copy of the police report or case number. If a police report or case number is not available, the MCE shall submit a copy of the provider's entry in the member's medical record, which must be signed by the provider, or a copy of the MCE's entry into the member's case file signed by the applicable MCE personnel, or both, that documents the report to law enforcement or any other reasonable evidence.¶
(6) Approval or Denials of MCE Requests for Disenrollment Due to Uncooperative or Disruptive Behavior, Acts of Violence, or Credible Threats of Violence.¶
(a) MCE requests made without all documentation, including CCO AR requests for additional or clarifying information, required under sections (4) and (5) of this rule shall be denied:¶
(A) When there is insufficient documentation submitted with a request for disenrollment, the CCO AR shall notify the MCE of the denial within two business days of the initial request;¶
(B) MCEs may submit a new request for disenrollment once all required documentation is completed and available to be provided to the CCO AR.¶
(b) After receipt of a complete MCE request for disenrollment, the request will be evaluated by the MCE's CCO AR and relevant subject matter experts, including those with licensure or certification, as well as expertise appropriate to the circumstances identified in the request for disenrollment (disenrollment review team);¶
(c) The CCO AR will document the review, recommendations, and rational with relevant regulatory or clinical criteria made by the disenrollment review team:¶
(A) The CCO AR shall provide the documentation and recommendations made by the disenrollment review team to Authority's management for a decision regarding disenrollment of the affected member;¶
(B) The documentation provided to Authority management by the CCO AR shall also include the name of all disenrollment review team members, their respective areas of expertise, licensure or certification, or both;¶
(C) The decision, and all individuals involved in making the decision to approve or deny an MCE request for disenrollment under this section (6) of this rule shall be documented in the affected member's case file maintained by the Authority.¶
(d) The CCO AR shall provide written notice on Authority letterhead to the MCE of the Authority's decision to approve or deny the MCE's request for disenrollment. The CCO AR shall provide copies of the notice to the MCE CEO, MCE COO, and the Authority Medicaid Director~~:~~.¶
(A) All notices of disenrollment approvals and denials shall include the reason for the decision along with applicable, supporting regulatory or clinical criteria, or both, and identify the subject matter expertise and credentials of the disenrollment review team. However, the names of the individuals on the disenrollment review team shall not be included in the notice;¶
(B) When there is sufficient documentation for the CCO AR to convene a disenrollment review team, the notice of approval or disapproval of the request for disenrollment shall be made by the Authority within 15 business days of receipt of the request for disenrollment.¶
(e) The CCO AR shall provide the affected member with written notice of their disenrollment within five business days after the Authority has approved the MCE's request for disenrollment. A copy of the member notice shall be sent to the MCE, which the MCE shall distribute to the member's care team. A copy of the member notice shall be placed in the member's case file maintained by the Authority. The notice of disenrollment provided to the member

shall include all of the following information:¶
(A) The disenrollment date;¶
(B) The reason for disenrollment;¶
(C) Information regarding the member's right to file a grievance and their administrative hearing rights; and¶
(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in the Authority's record of the request and provided to the MCE for distribution the member's care team.¶
(f) The date of disenrollment shall be effective ten calendar days after the date of the member's disenrollment notice, unless:¶
(A) The member files a grievance or otherwise requests a hearing, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon such decisions; or¶
(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE will be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.¶
(7) Enrollment for Authority Approved Disenrollment.¶
(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or¶
(b) When circumstances permit, and there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or¶
(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR will place an enrollment exemption for the appropriate MCE CCO-A, CCO-B, CCO-E, CCOF, and CCO-G plans and place the member on Open Card for a twelve month period, after which the CCO AR will reevaluate enrollment options for the member.¶
(8) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the MCE, all disenrollments are effective the end of the month the Authority approves the disenrollment:¶
(a) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority;¶
(b) If the member dies, the last date of enrollment shall be the date of the member's death.¶
(9) Transfers of 500 or more members.¶
(a) As specified in ORS 414.647711, the Authority may approve the transfer of 500 or more members from one MCE to another MCE if:¶
(A) The member's provider has contracted with the receiving MCE and the provider has stopped accepting patients from the MCE from which the member is being transferred, or has terminated providing services to members who are enrolled with the MCE from which the member is being transferred;¶
(B) Members are offered the choice of remaining enrolled in the transferring MCE; and¶
(C) The member and all family (case) members shall be transferred to the provider's new MCE.¶
(b) The transfer shall become effective the date on which the provider's contract with their current MCE terminates or otherwise expires, or on another date approved by the Authority;¶
(c) Members shall not be transferred under this section (9) unless the following conditions have been satisfied:¶
(A) The Authority has evaluated the receiving MCE and determined that the receiving MCE meets criteria established by the Authority as stated in OAR 410-141-3705 including, but not limited to, ensuring that the MCE maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and¶
(B) The Authority has provided notice of a transfer to members affected by the transfer at least 90 calendar days before the scheduled date of the transfer.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065, ORS 414.727

AMEND: 410-141-3840

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3840
Emergency and Urgent Care Services
(1) CCOs shall have written policies, procedures, and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all members. CCOs shall:¶
(a) Communicate these policies and procedures to participating providers;¶
(b) Regularly monitor participating providers' compliance with these policies and procedures; and¶
(c) Take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.¶
(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or orally appropriate response as indicated to urgent or emergency calls including but not limited to the following:¶
(a) Telephone or face-to-face evaluation of the member;¶
(b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;¶
(c) Development of a course of action;¶
(d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound;¶
(e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and¶
(f) Provision for notifying other providers that prior authorization is required for post-stabilization care in accordance with this rule.¶
(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.¶
(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:¶
(a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;¶
(b) The CCO may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;¶
(c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not timely billed for the service.¶
(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, whether for physical, behavioral, or ~~oral health~~dental services, whether in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:¶
(a) Pre-authorized by the CCO;¶
(b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or¶
(c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.¶
(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:¶
(a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's

care;¶
(b) The participating provider assumes responsibility for the member's care through transfer;¶
(c) A CCO representative and the treating provider reach an agreement concerning the member's care; or¶
(d) The member is discharged.¶
(7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services~~. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for oral health care~~:¶
(a) CCOs shall educate members about, and support them in, how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;¶
(b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.¶
(8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3865

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3865
Care Coordination Requirements
(1) CCOs shall ensure continuous care management for all members.¶
(2) For the purpose of OARs 410-141-3860 - 410-141-3870, the following meanings apply:¶
(a) "Health Risk Screening" means:¶
(A) A systematic collaborative approach by the CCO and provider to collecting information from a Member about key areas of their health for the purpose of:¶
(i) Assessing the Member's health;¶
(ii) Evaluating the Member's level of health risk; and¶
(iii) Providing the Member with individualized feedback about the results of the screening and evaluation with the goal of motivating behavioral changes to reduce health risks, maintain health, and prevent disease.¶
(B) Results of the Health Risk Screening shall be documented in the member's care plan.~~:~~¶
(C) Health Risk Screenings are usually administered through a survey or questionnaire. Suggested areas of information to collect include questions, depending on the Member's age, regarding:¶
(i) Demographics, such as age, gender, relationship status;¶
(ii) Lifestyle behaviors, such as exercise, eating habits, alcohol and tobacco use, activities of daily living;¶
(iii) Living Conditions such as access to food, housing and related living conditions;¶
(iv) Behavioral/emotional health, such as stress, mood, life events, abuse;¶
(v) Physical health, such as weight, height, blood pressure; ~~and~~¶
(vi) Personal and family health history~~.~~; and¶
(vii) Dental health. ¶
(b) "Intensive Care Coordination (ICC) Assessment" means the utilization of standardized tools, instruments, or processes for the purpose of identifying, and creating individual, personalized treatment and service plans to address the specific physical, behavioral, oral, and social needs of Priority Population Members, as well as other Members who have been identified, as a result of their Health Risk Screenings, as potentially in need of ICC Services, or having experienced a triggering event as set forth in OAR 410-141-3870(9).¶
(3) CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member in accordance with OAR 410-141-3870. This screening is distinct from the assessment of special health care needs:¶
(a) CCOs shall use a screening process to evaluate all members for critical risk factors that trigger the need for intensive care coordination for members with special health care needs;¶
(b) Members shall be screened upon initial enrollment with their CCO. This screening shall be completed as follows:¶
(A) Within 90 days of the effective date of initial enrollment;¶
(B) Within 30 days of the effective date of initial enrollment when the member is:¶
(i) Referred; ~~or~~¶
(ii) Receiving Medicaid-funded long-term care, services and supports (LTSS); or¶
(iii) Is a member of a priority population as such term is defined in OAR 410-141-3870~~; or.~~¶
(C) Sooner than required under (3)(b)(A) or (B) of this rule if required by the member's health condition.¶
(c) CCOs shall rescreen members annually or sooner if there is a change in health status indicating need for an updated assessment. Members shall be rescreened in accordance with this section (3)(c) of this rule even if they have previously declined care coordination or ICC services;¶
(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;¶
(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.¶
(4) CCOs shall document all screenings and assessments in the member's case file:¶
(a) If a CCO requires additional information from the member to complete a screening or assessment, the CCO shall document all attempts to reach the member by telephone and mail;¶
(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;¶
(c) CCOs shall share the results of member assessments and screenings consistent with ORS 414.607 and all other applicable state and federal privacy laws with the following:¶

(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;¶
(B) The state or other MCEs serving the member;¶
(C) Members receiving LTSS and, if approved by the member, their case manager and their LTSS provider, if approved by the member; and¶
(D) With Medicare Advantage or DSNP plans serving dual eligible members.¶
(5) CCOs shall have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and for identifying those members requiring referral to the Department for LTSS.¶
(6) CCOs shall require their care coordinators to develop, and CCOs shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ICC needs, including those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving LTSS.¶
(7) A member's care plan must at a minimum:¶
(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners;¶
(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member;¶
(c) Make provision for authorization of services in accordance with OAR 410-141-3835;¶
(d) For members enrolled in ICC or a condition-specific program, Intensive Care Coordination Plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care needs change.¶
(8) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:¶
(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;¶
(b) To ensure engagement and satisfaction with care plans, care coordinators shall:¶
(A) Actively engage members in the creation of care plans;¶
(B) Ensure members understand their care plans; and¶
(C) Ensure members understand their role and responsibilities outlined in their care plans.¶
(c) Care coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities;¶
(d) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as detailed in (8)(a)-(d) ~~abov~~of this rule;¶
(e) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providing the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above.¶
(9) A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.¶
(10) Care coordinators shall perform their care coordination tasks in accordance with the following principles:¶
(a) Use trauma informed, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-being;¶
(b) Work with members to set agreed-upon goals with continued CCO network support for self-management goals;¶
(c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;¶
(d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;¶
(e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;¶
(f) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and¶

(g) Have contact with, if the member is participating in a condition-specific program, the active condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.¶
(11) Care coordinators shall promote continuity of care and recovery management through:¶
(a) Episodes of care, regardless of the member's location;¶
(b) Monitoring of conditions and ongoing recovery and stabilization;¶
(c) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and¶
(d) Engaging members, and their family and caregivers as appropriate.¶
(e) For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.¶
(12) CCOs shall facilitate transition planning for members. In addition to the requirements of OAR 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below:¶
(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities;¶
(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:¶
(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;¶
(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and¶
(C) Engage with the member, in person within two days post discharge. For the duration of the Public Health Emergency (PHE), face-to-face contact may occur by synchronous telehealth as defined in OAR 410-141-3566.¶
(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on an in-person basis whenever possible or face-to-face by synchronous telehealth as defined in OAR 410-141-3566 for the duration of the Public Health Emergency (PHE), as follows:¶
(A) Within one business day of admission;¶
(B) Two times per week while the member is in acute care; and¶
(C) No less than two times per week within the week of discharge.¶
(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;¶
(e) In the event a member has a lapse in Medicaid coverage while admitted to a hospital, residential, inpatient, long-term care, or other similarly licensed in-patient facility, CCOs shall also, in addition to providing the services set forth in subsections (a)-(d) of this section (12) of this rule, oversee management of the member's care, work to establish services that may be needed but currently are not available in their service areas, and if eligible, assist in the reinstatement of Medicaid coverage. The CCO's obligation to provide such services shall continue for the period of 60 days from the date the member lost Medicaid coverage or until the member's discharge, whichever occurs sooner.¶
(13) CCOs shall ensure care coordinators are providing the required and appropriate behavioral, oral, and physical health care services and supports to members. The individual(s) tasked with responsibility for supervising care coordinators, whether employed by a CCO or employed by a Subcontractor providing care coordination services, shall be:¶
(a) A licensed master's-level mental health professional; or¶
(b) A licensed nurse by the State of Oregon, holding a Bachelor's degree or higher in nursing.¶
(14) CCOs shall not subcontract or otherwise delegate the responsibility for ensuring any subcontracted care coordination services and activities meet the requirements set forth in this rule, OARs 410-141-3860, 410-141-3870, and any other applicable care coordination requirements.
Statutory/Other Authority: 414.615, 414.625, 414.635, 414.651, ORS 413.042
Statutes/Other Implemented: ORS 414.610-414.685

AMEND: 410-141-3875

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3875
MCE Grievances & Appeals: Definitions and General Requirements
(1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:¶
(a) "Appeal" means a review by an MCE, pursuant to OAR 410-141-3890 of an adverse benefit determination;¶
(b) "Adverse Benefit Determination" means any of the following, consistent with 42 CFR 438.400(b):¶
(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;¶
(B) The reduction, suspension, or termination of a previously authorized service;¶
(C) A denial, in whole or in part, of a payment for a service. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination;¶
(D) The failure to provide services in a timely manner pursuant to OAR 410-141-3515;¶
(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;¶
(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or¶
(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.¶
(c) "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. For the purpose of this rule, pharmacy claims processed at point-of-sale (POS) that are rejected or denied shall not be considered "clean claims" that would trigger an NOABD;¶
(d) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;¶
(e) "Continuing benefits" means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910;¶
(f) "Grievance" means a member's expression of dissatisfaction to the MCE or to the Authority 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 member's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision;¶
(g) "Member." ~~With respect to~~for actions taken regarding grievances and appeals, ~~references to a~~ "member" includes, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to MCE notification requirements, a separate notice must be sent to each individual who falls within this definition;¶
(h) "Notice of Adverse Benefit Determination" means the notice must meet all requirements found at 42 CFR 438.400.¶
(2) MCEs shall establish and have an Authority approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:¶
(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;¶
(b) Member rights to appeal and request an MCE review of a notice of ~~action/~~adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;¶
(c) Member rights to request a contested case hearing regarding an MCE notice of ~~action/~~adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;¶
(d) An explanation of how MCEs shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;¶
(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;¶
(f) Specific to the appeals process, the policies shall:¶
(A) Consistent with confidentiality requirements, ensure the MCE's staff designated to receive appeals begins to

obtain documentation of the facts concerning the appeal upon receipt;¶
(B) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;¶
(C) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;¶
(D) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and¶
(E) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.¶
(3) The MCE shall provide information to members regarding the following:¶
(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;¶
(b) Member rights and responsibilities; and¶
(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.¶
(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR 438.408(b)(1) and (2) and these rules.¶
(5) Upon receipt of a grievance or appeal, the MCE shall:¶
(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;¶
(b) Give the grievance or appeal to staff with the authority to act upon the matter;¶
(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;¶
(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:¶
(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;¶
(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:¶
(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;¶
(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.¶
(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;¶
(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.¶
(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.¶
(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.¶
(8) The following pertains to the release of a member's information:¶
(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:¶
(A) Resolving the matter; or¶
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.¶
(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.¶
(9) The MCE shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:¶
(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;¶
(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR 438.10;¶

(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and¶
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.¶
(10) The MCE, its subcontractors, and its participating providers may not:¶
(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;¶
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or¶
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.¶
(11) In all MCE administrative offices and in those physical, behavioral, and ~~or~~dental 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 (OHP 3302; or approved facsimile);¶
(c) Hearing request form Request to Review a Health Care Decision (OHP 3302) or (MSC 443) and Notice of Hearing Rights (OHP 3030)~~; or.~~¶
(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.¶
(13) If at the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.¶
(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:¶
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;¶
(b) Monitor the subcontractor's performance on an ongoing basis;¶
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and¶
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3885

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3885
Grievances & Appeals: Notice of Action/Adverse Benefit Determination
(1) When an MCE has made an adverse benefit determination, the MCE shall ~~notify~~give the requesting provider ~~and give~~, the member and the member's representative a written notice of ~~action/~~adverse benefit determination ~~notice~~(NOABD). The notice shall:¶
(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;¶
(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule.¶
(2) The following are notice requirements for pre-service denials:¶
(a) Meet the content notice requirements specified in 42 CFR 438.404 and in the MCE contract, including the following information:¶
(A) MCE contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages;~~.~~¶
(B) Date of the notice;¶
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model~~;~~. If the member has not been assigned a practitioner because they enrolled in the MCE within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred~~.~~;¶
(D) Member's name, date of birth, address, and OHP member ID number;¶
(E) Service requested and the adverse benefit determination the MCE intends to make, including whether the MCE is denying, (in whole or part) terminating, suspending, or reducing a service;¶
(F) Date service was requested by the provider or member;¶
(G) Name of the provider who requested the service;¶
(H) Effective date of the adverse benefit determination if different from the date of the notice;¶
(I) Diagnosis and procedure codes submitted with the authorization request including a description in plain language if the MCE is denying a requested service because of line placement on the Prioritized List of Health Services or the diagnosis and procedure code do not pair on the Prioritized List;¶
(J) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830;¶
(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination;¶
(L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶
(M) The member's or, if the member provides their written consent as required under OAR 410-141-3890(1), the provider's right to file a written or oral appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(N) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;¶
(O) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;~~.~~¶
(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, the timeframes to request that benefits be continued as described in OAR 410-141-3910 and the circumstances under which the member may be required to pay the cost of these services; and¶
(Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse

benefit determination.¶
(b) Use an Authority approved NOABD notice 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 Adverse Benefit Determination~~NOABD.¶
(3) The following are notice requirements for Post-service denials:¶
(a) Meet the content notice requirements specified in 42 CFR 438.404 and in the MCE contract, including the following information:¶
(A) MCE contact information and subcontractor contact information, if applicable, included in the ABD notice excluding any cover pages;¶
(B) Date of the notice;¶
(C) MCE's name, address, and telephone number;¶
(D) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred;-¶
(E) Member's name, D.O.B, address, and OHP member ID number;¶
(F) Service previously provided and the adverse benefit determination the MCE made;¶
(G) Date the service was provided;¶
(H) Name of the provider who provided the service;¶
(I) Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;¶
(J) Diagnosis and procedure codes submitted on the claim including a description in plain language if the MCE is denying the service because of line placement on the Prioritized List of Health Services or the diagnosis and procedure code do not pair on the Prioritized List;¶
(K) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830;¶
(L) Clear and thorough explanation of the specific reasons for the adverse benefit determination;¶
(M) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶
(N) The member's or, if the member provides their written consent as required under OAR 410-141-3890~~(1)~~, the provider's right to file a written or oral appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(O) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;¶
(P) An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it, but that an expedited appeal and hearing will not be granted for post-service denials as the service has already been provided;-¶
(Q) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services;-¶
(R) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination; and¶
(S) A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166).-¶
(b) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the ~~Oregon's Notice of Action/Adverse Benefit Determination~~NOABD.¶
(4) The MCE shall provide a copy of the form, Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile, when the MCE issues a N~~otice of Adverse Benefit Determination.¶~~
~~(5) For requirements of notice of actions/adverse benefit determinations~~OABD.¶
(5) For requirements of NOABD that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.¶
(6) 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 notice that the services requested by the member are no longer desired or the MCE is provided with information that requires termination or reduction in services:¶
(i) All notices sent to a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;¶
(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.¶
(C) The MCE can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;¶
(D) The MCE is unaware of the member's ~~whereabouts~~location 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 has:¶
(A) ~~Has f~~Facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and¶
(B) ~~The MCE has v~~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.¶
(7) 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: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3890

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3890
Grievances & Appeals: Appeal Process
(1) A member, member representative, or a subcontractor or provider with the member's written consent, may file an oral or written appeal with the MCE to:¶
(a) Express disagreement with an adverse benefit determination; or¶
(b) Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative. If the member leaves a voice mail message with the MCE indicating that they wish to appeal a denial the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt to reach the member (date(s) and time(s)) by phone and make note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.¶
(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 (including as necessary multiple calls at different times of day) 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;¶
(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.¶
(4) For expedited resolution of an appeal please see OAR 410-141-3895. A request for an expedited appeal for a service that has already been provided to the member (post-service) will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above ~~in (3),~~section (3) of this rule.¶
(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.¶
(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:¶
(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date;¶
(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.¶
(7) Parties to the appeal include, as applicable:¶
(a) The member and their representative; or¶
(b) The legal representative of a deceased Member's estate.¶
(8) The MCE shall resolve each standard appeal in time period defined above in section (4) of this rule. The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.¶
(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.¶
(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.¶

(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of ~~action/~~adverse benefit determination, as specified in OAR 410-141-3885, in addition to:¶
(a) The results of the resolution process and the date the MCE completed the resolution; and¶
(b) For appeals not resolved wholly in favor of the member:¶
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;¶
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;¶
(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and¶
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;¶
(E) Copies of the appropriate forms: Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3920

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3920
Transportation: NEMT General Requirements
(1) A CCO shall provide all non-emergency medical transportation (NEMT) services for its members. For purposes of OAR 410-141-3920 to 410-141-3965, references to a "member" include any individual eligible for NEMT services under ~~this section (1) unless context dictates otherwise.~~section (1) of this rule unless context dictates otherwise:¶
(a) The CCO is responsible for NEMT services for all of its members' health care services consistent with the covered services described in OAR 410-141-3820 and the excluded services and limitations described in 410-141-3825 and (1)(b) and (1)(c) of this rule;¶
(b) NEMT services for those health care services that, based on the member's plan type, are paid by the Authority's fee-for-service program and that, based on rule or contract, are carved-out from or otherwise not covered by the CCO and provided by the Authority;¶
(c) For members enrolled in the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program, both of which are defined in OAR chapter 410, division 200, the CCO is responsible only for NEMT services related to the member's dental services. ¶
(2) A CCO shall provide a toll-free call center for members to request rides.¶
(3) Neither a CCO nor any of its Subcontracted transportation providers may bill a member for transport to or from covered medical services, even if the CCO or its contracted transportation provider denied reimbursement for the transportation services.¶
(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).¶
(5) A CCO shall have written policies and procedures regarding its NEMT services. All policies and procedures must be provided to all Members either in Contractor's Member Handbook or in a stand-alone document referred to as a "NEMT rider guide" that meets the delivery and content specifications as defined by ~~OHA~~the Authority. The CCO's written policies and procedures regarding NEMT services shall provide, without limitation, for the following:¶
(a) Allow members or their representatives to schedule:¶
(A) NEMT services up to 90 days in advance;¶
(B) Multiple NEMT services at one time for recurring appointments up to 90 days in advance; and¶
(C) Same-day NEMT services.¶
(b) Comply with the following criteria for member drop-offs and pick-up protocols:¶
~~(A) Not permit drivers to d~~. Drivers are not permitted to:¶
(A) Drop Members off at an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the member or, as applicable, the Member's guardian, parent, or representative; and¶
(B) ~~Not permit drivers to p~~Pick up Members from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the member, or as applicable, the Member's guardian, parent, or representative.¶
(c) Describe passenger rights and responsibilities as set forth in 42 CFR §438.210, and as set forth in OARs 410-141-3920 through 410-141-3960, and other state and federal administrative statutes and rules relating to the rights and responsibilities of Medicaid recipients such as the right to file a grievance and request an appeal or reconsideration.¶
(6) The grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 are available with respect to NEMT services, with the following modifications:¶
(a) Prior to mailing a notice of adverse benefit determination to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.¶
(b) The CCO shall mail, within 72 hours of denial, a notice of adverse benefit determination to:¶
(A) A member denied a ride; and¶
(B) CCOs shall provide a copy of the NOABD to the provider with which the affected member was scheduled for an appointment, when the provider is part of the CCO's provider network and requested the transportation on the member's behalf, in a format that is agreeable to the provider and provides sufficient documentation of notification.

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

AMEND: 410-141-3960

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-3960
Transportation: Member Reimbursed Mileage, Meals, and Lodging
(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.¶
(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.¶
(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. The OHP fee schedule is available on the Authority's website.¶
(4) The member must return any documentation a CCO requires before receiving reimbursement.¶
(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.¶
(6) A CCO shall reimburse members for meals when a member travels:¶
(a) Out of their local area as outlined in OAR 410-141-3515~~(4)(a) and (b); and~~; ¶
(b) For a minimum of four hours round-trip; or¶
(c) The travel must span the following meal times:¶
(~~b~~A) For a ~~minimum of four hours round-trip~~breakfast allowance, the travel must begin before 6:00 a.m.;¶
(B) For a lunch allowance, the travel must span the entire period from 11:30 a.m. through 1:30 p.m.; and¶
(C) For a dinner allowance, the travel must end after 6:30 p.m.¶
(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:¶
(a) A member would otherwise be required to begin travel before 5:00 a.m. in order to reach a scheduled appointment; or¶
(b) Travel from a scheduled appointment would end after 9:00 p.m.; or¶
(c) The member's health care provider documents a medical need.¶
(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.¶
(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:¶
(a) The member is a minor child and unable to travel without an attendant;¶
(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;¶
(c) The member is mentally or physically unable to reach their medical appointment without assistance; or¶
(d) The member is or would be unable to return home without assistance after the treatment or service.¶
(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCO's discretion.¶
(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:¶
(a) For mileage, meals, and lodging, and another resource also paid:¶
(A) The member; or¶
(B) The ride, meal, or lodging provider directly~~;~~.¶
(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;¶
(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.¶
(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-5015

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Oregon Health Plan

CHANGES TO RULE:

410-141-5015
FINANCIAL SOLVENCY REGULATION: Financial Statement Reporting
(1) ~~A CCO shall submit the following financial reports to the Authority~~Financial reports to the Authority. A CCO shall submit the following:¶
(a) On or before April 30 of each year, ~~a CCO shall submit~~ an unaudited financial statement for the year ending December 31 immediately preceding.~~:~~¶
(b) On or before May 31, August 31, and November 30 of each year, ~~a CCO shall submit~~ an unaudited financial statement for the quarter ending March 31, June 30 and September 30, respectively.~~:~~¶
(c) On or before June 30 of each year, ~~a CCO shall submit~~ an audited financial statement for the year ending December 31 immediately preceding.¶
(2) Except as otherwise allowed or required by the Authority, all annual and quarterly financial statements filed by a CCO with the Authority shall:¶
(a) Follow and be presented in accordance with Statutory Accounting Principles~~,~~;¶
(b) Use NAIC Forms and Instructions~~,~~;¶
(c) Be verified by the oaths of the president and secretary of the CCO or, in their absence, by two other duly authorized and acting principal officers; and¶
(d) Include the additional information listed in ~~sub~~sections (4), (5) and (6) of this ~~section~~rule.¶
(3) Audited annual financial statements shall be subject to, and shall comply with, the additional requirements set forth in OAR 410-141-5020 through OAR 410-141-5040. NAIC Forms and Instructions are available for inspection at the office of the Authority. Any person interested in inspecting the NAIC Forms and Instructions may contact the Authority at actuarial.services@dhsoha.state.or.us. A CCO shall be responsible for purchasing the current software version of the NAIC Forms and Instructions from the NAIC as required to prepare the financial statement filings required by these rules.¶
(4) A CCO shall include the following as supplements to the CCO's quarterly and annual financial statement filings, using forms and templates prescribed by the Authority:¶
(a) A Supplemental Compensation Exhibit, as published by the NAIC, disclosing the salary and benefits of the three officers or employees having the highest total compensation for the period. This exhibit shall be required only with the CCO's annual financial statement filing.~~:~~¶
(b) A report of Health-Related Services (as defined by OAR 410-141-~~3~~50150 and as described in Oregon's Medicaid 1115 Waiver for 2017 - 2022) and additional supplemental information, including care coordination, case management, flexible services, and community benefit expenses. CCOs shall comply with the following additional requirements regarding Health-Related Services (as defined by OAR 410-141-~~31~~5015 and as described in the CMS section 1115 Waiver):¶
(A) Health Related Services shall be considered in the rate setting consistent with the current 1115 Waiver.~~:~~¶
(B) Health Related Services shall be included as Activities that Improve Health Care Quality in the Minimum Medical Loss Rebate Calculation report.¶
(c) A certification of compliance with financial and encounter data reporting requirements.~~:~~¶
(d) A report of third-party resources collections (CCO contractor).~~:~~¶
(e) A report of Corporate Relationships of Contractors ~~(FCHPs, DCOs, and PCOs)~~ and Incentive Plan Disclosure and Detail (CCOs).~~:~~¶
(f) CCO-specific utilization reports.~~:~~¶
(g) Any other supplemental information deemed necessary by the Authority and specified in Exhibit L to the CCO's contract with the Authority.¶
(5) A CCO shall report the following information in respect of the CCO's Restricted Reserve, using forms and templates prescribed by the Authority:¶
(a) Identification of custodians, account balances and assets comprising Restricted Reserve Funds held by a third-party.~~:~~¶
(b) A bank statement from each custodian of Restricted Reserve Funds of the account balance or aggregate fair market value of the assets comprising the Restricted Reserve Funds held by the custodian.~~:~~¶
(c) Documentation of the liability that would be owed to creditors in the event of the CCO's insolvency.~~:~~¶
(d) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.¶

(6) A CCO shall report the following information in respect of any Sub-Capitation Arrangements to which the CCO is a party, using forms and templates prescribed by the Authority:¶
(a) A CCO that sub-capitates any work described in its agreements with the Authority shall require the Sub-Capitated Counterparty to report financial information as specified in the CCO's agreements with the Authority.;¶
(b) CCOs that make sub-capitation payments exceeding an annual amount defined by financial reporting instructions under the CCO's contract shall submit to the Authority on an annual basis the following financial reports with respect to each of the CCO's Sub-Capitated Counterparties:¶
(A) Statements of revenue, expenses and net income.;¶
(B) Restricted Reserve Account documentation.;¶
(C) Certification of compliance with financial and encounter data reporting requirements.;¶
(D) Any supplemental information deemed necessary by the Authority.¶
(7) Following termination of the CCO contract, the annual reports described in this ~~section~~rule are due for the last calendar year during which the CCO operated, and its quarterly reports are due until its last annual report has been filed.¶
(8) The CCO shall make such additional filings with the Authority as are required by the CCO's agreement with the Authority and as otherwise may be determined by the Authority from time to time to be necessary under the circumstances.
Statutory/Other Authority: ORS 413.042, ORS 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610-414.685

AMEND: 410-200-0315

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Describes income limits for HSD Medical Programs, updates made to include income limits for the COFA and Veteran Dental Programs.

CHANGES TO RULE:

410-200-0315
Standards and Determining Income Eligibility ¶

(1) This rule outlines income thresholds for HSD Medical Programs. See OAR 410-200-0310 for eligibility and budgeting.¶
(2) The ~~MAGI-based~~ income standard for the MAGI Parent or Caretaker-Relative program is set as follows: See attached table.¶
(3) Effective March 1, 2022, the ~~MAGI~~ income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the 2022 FPL as follows: See attached table.¶
(4) Effective March 1, 2022, the ~~MAGI~~ income standard for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under the age of one year is set at 185 percent of the 2022 FPL as follows: See attached table.¶
(5) Effective March 1, 2022, the ~~MAGI income standard for the MAGI CHIP p~~income standard for MAGI CHIP is set at 300 percent of the 2022 FPL as follows: See attached table.¶
(6) Effective January 1, 2023, the income standard for the COFA Dental Program is set at 138 percent of the 2022 FPL as follows: See attached table.¶
(7) Effective January 1, 2023, the income standard for the Veteran Dental Program is set at ~~3~~400 percent of the 2022 FPL as follows: See attached table.¶
(~~6~~8) When the Department makes an ELE determination and the child meets all MAGI CHIP or MAGI Child Program nonfinancial eligibility requirements, the EDG size determined by the Department is used to determine eligibility regardless of the family size. The countable income of the household is determined by the ELA. A child is deemed eligible for MAGI CHIP or MAGI Child Program as follows:¶
(a) Effective March 1, 2022, if the MAGI-based income of the EDG is below 163 percent of the 2022 federal poverty level, the Department deems the child eligible for the MAGI Child Program: See attached table.¶
(b) If the MAGI-based income of the EDG is at or above 163 percent FPL through 300 percent FPL as described in section (4) of this rule, the Department deems the child eligible for MAGI CHIP.
Statutory/Other Authority: 42 CFR 435.110, ORS 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.608, 433.138, 433.145, 433.146, 433.147, 433.148, 435.117, 435.119, 435.1200, 435.1205, 435.170, 435.190, 435.222, 435.610, 435.916, 435.917, 447.56, 457.350, 457.360, 457.805, ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.402, 411.404, ORS 411.060, 411.095, 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

ADOPT: 410-200-0445

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Describes financial and non-financial eligibility requirements for the COFA Dental Program.

CHANGES TO RULE:

410-200-0445
Specific Requirements - Compact Of Free Association (COFA) Dental Program
(1) The Compact of Free Association (COFA) Dental Program is effective January 1, 2023. ¶
(2) To be eligible for the COFA Dental Program, an individual must:¶
(a) Be lawfully residing in the United States in accordance with the Compacts of Free Association (I.e., the governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau);¶
(b) Be a resident of Oregon; and¶
(c) Have MAGI-based income (see OAR 410-200-0015 General Definitions (55)) within 138% FPL;¶
(3) To be eligible for the COFA Dental Program, an individual must not be eligible for Medicaid under Title XIX of the Social Security Act or the Children's Health Insurance Program under Title XXI of the Social Security Act.¶
(4) The begin-date of COFA Dental Program benefits will align with OAR 410-200-0115 HSD Medical Programs - Effective Dates.¶
(5) The Agency shall accept self-attestation of the eligibility requirements described in this rule, unless questionable.
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706

ADOPT: 410-200-0450

NOTICE FILED DATE: 09/30/2022

RULE SUMMARY: Describes financial and non-financial eligibility requirements for the Veteran Dental Program, including information about the Veteran Dental Reservation list, which will be enacted if/when enrollment in the plan reaches budget capacity.

CHANGES TO RULE:

410-200-0450
Specific Requirements - Veteran Dental Program
(1) The Veteran Dental Program is effective January 1, 2023.¶
(2) To be eligible for the Veteran Dental Program, an individual must:¶
(a) Be a resident of Oregon;¶
(b) Be a veteran as described in ORS 408.225, except the individual may be discharged or released under honorable conditions or other conditions; and¶
(c) Have MAGI-based income (see OAR 410-200-0015 General Definitions (55)) within 400% FPL.¶
(3) Individuals found eligible for the Veteran Dental Program must provide verification of discharge as a condition of ongoing eligibility.¶
(4) To be eligible for the Veteran Dental program an individual must not be eligible for Medicaid under Title XIX of the Social Security Act or the Children's Health Insurance Program under Title XXI of the Social Security Act, except an individual may be eligible for and receive Medicare Savings Programs.¶
(5) The begin-date of Veteran Dental Program benefits will align with OAR 410-200-0115 HSD Medical Programs - Effective Dates.¶
(6) Eligibility for Veteran Dental Program is subject to the availability of funds. The agency may close enrollment and implement the Veteran Dental Program reservation list when enrollment has reached capacity. The reservation list will retain the information of individuals who would have been found eligible for the Veteran Dental Program if not for closed enrollment.¶
(a) Individuals who apply and are denied the Veteran Dental Program due solely to closed enrollment will be added to the reservation list in date-order, based on the Date of Request (DOR) of the application that was denied.¶
(b) When enrollment is reopened, individuals will be selected from the reservation list in oldest to newest DOR date order. Once selected, the agency shall:¶
(A) Initiate a DOR on the individual's behalf;¶
(B) Send notification to inform the individual that they've been selected from the reservation list;¶
(C) Provide 45 days to reapply.¶
(c) Failure to reapply within the timeframe provided will result in inactivation of their reservation. Individuals may reapply at any time.
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025
Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706