



PERMANENT ADMINISTRATIVE ORDER

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

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RULES:

410-141-0020, 410-141-0050, 410-141-0065, 410-141-0080, 410-141-0120, 410-141-0140, 410-141-0180, 410-141-0200, 410-141-0220, 410-141-0270, 410-141-0320, 410-141-0340, 410-141-0400, 410-141-0405, 410-141-0407, 410-141-0440, 410-141-0480, 410-141-0500, 410-141-0520, 410-141-0860, 410-141-3000, 410-141-3010, 410-141-3015, 410-141-3020, 410-141-3025, 410-141-3030, 410-141-3040, 410-141-3041, 410-141-3050, 410-141-3060, 410-141-3061, 410-141-3066, 410-141-3070

REPEAL: 410-141-0020

RULE TITLE: Administration of Oregon Health Plan Regulation and Rule Precedence

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan (OHP) pursuant to ORS 414.065 (generally, fee-for-service), 414.651 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.
- (2) In applying its policies, procedures, rules and interpretations, Division will construe them as much as possible to be complementary. In the event that the Division's policies, procedures, rules and interpretations may not be complementary, The Division will apply the following order of precedence to guide its interpretation:
- (a) For purposes of the provision of covered medical assistance to Division clients, including but not limited to authorization and delivery of service, or denials of authorization or services, the Division, clients, enrolled providers and the prepaid health plans (PHP) apply the following order of precedence:
- (A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers

granted Division by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the OHP;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for PHPs, requirements applicable to the provision of covered medical assistance to Division clients are provided in OAR 410-141-0000 through 410-141-0860, OHP administrative rules for prepaid health plans, inclusive, and where applicable, the Division's General Rules, 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to Division clients are provided in the Division's General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in 410-141-0480 to 410-141-0520, and the provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Authority necessary to administer the State of Oregon's medical assistance programs, such as Electronic Data Transaction rules in OAR 943-120-0100 to 943-120-0200; and

(F) The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0350 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of the OHP and medical assistance programs administered by the Division. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in subsections (i)–(v) of this section.

(b) For purposes of contract administration solely as between the Division and its PHPs, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to Division clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: 414.065

REPEAL: 410-141-0050

RULE TITLE: MHO Enrollment for Children Receiving Child Welfare Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

Pursuant to and in the administration of the Authority in OAR 410-141-0060, Children, Adults and Families (CAF) or the Oregon Youth Authority (OYA) selects Prepaid Health Plans (PHPs) for a child receiving CAF Child Welfare services or OYA services with the exception of children in subsidized adoption and guardianship. This rule implements and further describes how the Oregon Health Authority (Authority) shall administer its authority under 410-141-0060 and 410-141-3060 for purposes of making enrollment decisions and 410-141-0080 and 410-141-3080 for purposes of making disenrollment decisions for children receiving CAF Child Welfare services or OYA services;

(1) The Authority has determined that, to the maximum extent possible, all children receiving CAF services should be enrolled in Mental Health Organizations (MHOs) or Coordinated Care Organizations (CCO) at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment from a MHO or CCO is authorized by the Authority in accordance with this section and OAR 410-141-0080 and 410-141-3080:

(a) Notwithstanding OAR 410-141-0060(4)(a) or 410-141-3060 or 410-141-0080(2)(b)(E) or 410-141-3080, children receiving CAF services are not exempt from mandatory enrollment in an MHO or CCO on the basis of third party resources (TPR) mental health services coverage;

(b) A decision to use fee-for-service (FFS) open card for a child receiving CAF services should be reviewed by the Authority if the child's circumstances change and at the time of redetermination to consider whether the child should be enrolled in a MHO or CCO.

(2) When a child receiving CAF services is being transferred from one MHO to another or one CCO to another or for children transferring from FFS to a MHO or CCO, the MHO or CCO shall facilitate coordination of care consistent with OAR 410-141-0160 or 410-141-3160:

(a) MHOs and CCOs shall work closely with the Authority to ensure continuous MHO or CCO enrollment for children receiving CAF services;

(b) If the Authority determines that disenrollment should occur, the MHO or CCO shall continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible MHO or CCO.

(3) It is not unusual for a child receiving CAF services to experience a change of placement that may be permanent or temporary in nature. Consistent with OAR 410-141-0080 or 410-141-3080, the Authority will verify the address change information to determine whether a child receiving CAF services no longer resides in the MHO's or CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the MHO's or CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to a placement in the MHO's or CCO's service area at the end of the temporary placement;

(b) Unless a corresponding change in MHO capitation rates is implemented, a child receiving CAF services placed in behavioral rehabilitation services (BRS) settings shall be enrolled in the MHO or CCO that serves the region in which the BRS setting is located, unless an out of area exception is requested by the MHO or CCO and agreed to by the Authority for purposes related to continuity of care.

(4) If the child receiving CAF services is enrolled in a MHO or CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the MHO or CCO shall be responsible for covered services during that placement

even if the location of the facility is outside of the MHO's or CCO service area:

(a) The child receiving CAF services is presumed to continue to be enrolled in the MHO or CCO with which the child was most recently enrolled. An admission to a PRTS facility shall be deemed a temporary placement for purposes of MHO or CCO enrollment. Any address change or Authority system identifier (e.g., C5 status) change associated with the placement in the PRTS facility does not constitute a change of residence for purposes of MHO or CCO enrollment and shall not constitute a basis for disenrollment from the MHO or CCO, notwithstanding OAR 410-141-0080 and 410-141-3080. 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 MHO or CCO and assign an enrollment date that provides for continuous MHO or CCO coverage with the appropriate MHO or CCO. If the child had been enrolled in a different MHO or CCO in error, the Authority shall disenroll the child from that MHO or CCO and recoup the capitation payments;

(b) Immediately upon discharge from long-term psychiatric care and prior to admission to a PRTS, a child receiving CAF services should be enrolled in an MHO or CCO. At least two weeks prior to discharge of a child receiving CAF services from a long-term psychiatric care (SAIP, SCIP, or STS) facility to a PRTS facility, the long-term care facility shall consult with the Authority about which MHO or CCO will be assigned in order to provide for enrollment in the MHO or CCO and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge from long-term psychiatric care.

(5) Notwithstanding OAR 410-141-0060(6) and (7), 410-141-3060, 410-141-0080, and 410-141-3080, if a child receiving CAF services is enrolled in a MHO or CCO after the first day of an admission to PRTS, the date of enrollment shall be effective the next available enrollment date following discharge from PRTS to the MHO or CCO assigned by the Authority:

(a) For purposes of these rules and to assure continuity of care for the child upon discharge, the next available enrollment date shall mean immediately upon discharge;

(b) At least two weeks prior to discharge, the PRTS facility shall consult with the Authority about which MHO or CCO will be assigned and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: 414.065

REPEAL: 410-141-0065

RULE TITLE: Fully Capitated Health Plan or Physician Care Organization (FCHP or PCO) Enrollment Requirements for Individuals Receiving Residential Substance Use Disorder (SUD) Treatment Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

This rule implements and further describes how the Oregon Health Authority (Authority) will administer its authority under 410-141-0060 for purposes of making enrollment decisions and 410-141-0080 for purposes of making disenrollment decisions for the adult and adolescent individuals receiving residential SUD treatment services;

(1) The Authority has determined that, to the maximum extent possible, all individuals should be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment is authorized by the Authority in accordance with this section, OAR 410-141-0050 and OAR 410-141-0080

(2) If the Authority determines that disenrollment should occur, the FCHP or PCO will continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible FCHP or PCO when applicable.

(3) It is not unusual for individuals to receive residential SUD treatment services outside of their residential or home county and outside of the FCHP or PCO's delivery service area. Receiving residential SUD treatment is considered a temporary absence from the individual's residential or home county and does not represent a change of residence or a change in enrollment when the individual is reasonably likely to return to the FCHP or PCO's delivery service area at the end of the residential treatment stay.

(4) If the individual is enrolled in a FCHP or PCO on the same day the individual is admitted to the residential treatment services, the managed care organization shall be responsible for the covered services during that placement even if the location of the facility is outside of the FCHP or PCO's service area;

(5) The individual is presumed to continue to be enrolled in the FCHP or PCO with which the individual was most recently enrolled. An admission to a residential SUD facility is deemed a temporary placement and does not constitute a change of residence for the purposes of FCHP or PCO enrollment and does not constitute a basis for disenrollment from the FCHP or PCO, notwithstanding OAR 410-141-0080(2)(b)(F). If the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority will re-enroll the individual with the appropriate FCHP or PCO and assign an enrollment date that provides for continuous FCHP or PCO coverage with the appropriate FCHP or PCO. If the individual was enrolled in a different FCHP or PCO in error, the Authority will disenroll the individual and recoup the capitation payments.

(6) If the individual is enrolled in a FCHP or PCO after the first day of an admission to a residential SUD treatment service facility, the individual will be retro effectively disenrolled from the FCHPO or PCO, and capitation will be recouped. The date of enrollment shall be effective the next available enrollment date following discharge from the residential FCHP or PCO treatment service facility.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610-685

REPEAL: 410-141-0080

RULE TITLE: Managed Care Disenrollment from Prepaid Health Plans

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

For purposes of this rule, "Managed Care Prepaid Health Plan" means Fully Capitated Health Plan, Dental Care Organization, Physician Care Organization, and Mental Health Organization.

(1) All Oregon Health Plan (OHP) member-initiated requests for disenrollment from a Prepaid Health Plan (PHP) shall be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, 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.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority and PHP shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Newly eligible members may change their PHP assignment within 12 months following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months;

(C) Existing members may change their PHP assignment within 30 days of the Authority's automatic assignment or reenrollment in a PHP;

(D) In accordance with ORS 414.645, members may disenroll from a PHP during their redetermination (enrollment period) or one additional time during their enrollment period based on the members choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

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

(C) Members who are receiving Medicare (dual eligible) and who are enrolled in a PHP that has a corresponding Medicare Advantage component shall be disenrolled from the PHP if the contractor has declared its decision to disenroll members in accordance with OAR 410-141-0060 in the annual Dual Eligible Clients with Medicare Advantage Plans (Schedule 5) form. The effective date of disenrollment from the PHP shall be the first of the month following the date of request for disenrollment. Dual eligible shall receive choice counseling prior to reassignment;

(D) PHP does not, because of moral or religious objections, cover the service the member seeks;

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

(F) 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 experienced in dealing with the member's health care needs.

Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the PHP's service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of a member or a provider of a treatment, service, or supply including, but not limited to, a decision of a provider to participate or decline to participate in a PHP;

(iv) As specified in ORS 414.645, the Authority may approve the transfer of 500 or more members from one PHP to another PHP if:

(I) The members' provider has contracted with the receiving PHP and has stopped accepting patients from or has terminated providing services to members in the transferring PHP; and

(II) Members are offered the choice of remaining enrolled in the transferring PHP; and

(III) The member and all family (case) members shall be transferred to the provider's new PHP;

(IV) The transfer shall take effect when the provider's contract with their current PHP contractual relationship ends or on a date approved by the Division;

(V) Members may not be transferred under section 2(E)(vi) until the Division has evaluated the receiving PHP and determined that the PHP meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the PHP 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

(VI) The Division shall provide notice of a transfer to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(G) Members whose request for disenrollment is denied shall receive notice in accordance with OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing over the denial.

(c) If the following conditions are met:

(A) The applicant is in the third trimester of her pregnancy and has just been determined eligible for OHP, or the OHP client has just been redetermined eligible and was not enrolled in a PHP within the past three months; and

(B) The new PHP the member is enrolled with 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; and

(C) The request to change PHP or return to FFS is made prior to the date of delivery;

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

(A) Transfer of a member from a PHP to a CCO or DCO;

(B) Involuntary transfer of a member from a PHP to another PHP; or

(C) Automatic enrollment of a member in a PHP.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another PHP unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment as stated in 410-141-0060(4), and the member meets disenrollment criteria state in 42 CFR 438.56(c)(2), or there isn't another PHP in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

(C) If the Division fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

(3) The PHP may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;

(c) Because of the member's utilization of services, either excessive or lack thereof;

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the PHP

disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(4) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the PHP requests it for cause that includes, but is not limited to, the following:

(a) Member commits fraudulent or illegal acts related to the member's participation in OHP such as: permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The PHP shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 1-888-Fraud01 (1-888-372-8301) or <http://www.oregon.gov/DHS/ABUSE/Pages/fraud-reporting.aspx> consistent with 42 CFR 455.13;

(b) Member became eligible through a hospital hold process and placed in the Adults and Couples category as required under 410-141-0060(4).

(c) Requests by the PHP for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The PHP shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made;

(B) There shall be notification from the provider to the PHP at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the PHP. Such notification shall be documented in the member's clinical record. The PHP shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The PHP shall contact the member either verbally or in writing if it is a severe problem to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issues. Any contact with the member shall be documented in the member's clinical record. The PHP shall inform the member that their continued behavior may result in disenrollment from the PHP;

(D) The PHP shall provide individual education, disability accommodation, counseling, and other interventions with the member in a serious effort to resolve the problem;

(E) The PHP shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the PHP shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The PHP shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence, as the result of his or her special needs or disability, the PHP shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others shall actually occur, and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A PHP-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess

the behavior, the behavioral history, and previous history of efforts to manage behavior;

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

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

(v) Documentation of the PHP's rationale for concluding that the member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the member as a patient, the PHP shall attempt to locate another PCP on their panel who will accept the member as their patient. If needed, the PHP shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of members as patients shall be according to the PHP's policies and shall be consistent with PHP or PCP's policies for commercial members and with applicable disability discrimination laws. The PHP shall determine whether the PCP's termination of the member as a patient is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements as stated above, requests by the PHP for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56, the PHP shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the PHP's staff so that it seriously impairs the PHP's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member will cause grievous physical injury to others (including, but not limited to, death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The PHP shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an Exception to the Disenrollment Process of a Member;

(B) The provider shall immediately notify the PHP about the incident with the member. The notification shall describe the problem and shall be maintained for documentation purposes;

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

(D) The PHP shall provide any additional information requested by the CAR, the Authority, or Department of Human Services assessment team;

(E) If the member's behavior could reasonably be perceived as the result of his or her special needs or disability, the PHP shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined above;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others will actually occur, and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(F) Documentation shall exist that verifies the provider or PHP immediately reported the incident to law enforcement. The PHP shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinic record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures will not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the PHP's rationale for concluding that the member's continued enrollment in

the PHP seriously impairs the PHP's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the PHP's CAR or a team of CARs who may request additional information from Ombudsman Services or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;

(B) In cases where the member is also enrolled in the PHP's Medicare Advantage plan, the PHP shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is not sufficient documentation, the CAR shall notify the PHP within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

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

(E) Written decisions including reasons for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(5) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the PHP and the member's care team;

(b) The notice shall give the reason for the denial of the disenrollment request and the notice of a member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing in accordance with 42 CFR 438.56;

(c) Written decisions including the reason for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(6) The following procedures apply to all approved disenrollment requests:

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

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will proceed unless the member requests continued enrollment, pending a decision;

(c) The disenrollment effective date will be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment, pending a hearing decision. The disenrollment will take effect immediately upon the issuing of a hearing officer's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another PHP;

(e) If no other PHP is available to the member, the member will be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same PHP for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the PHP again requests disenrollment for cause, the request shall be referred to the OHA assessment team for review.

(7) Other reasons for the PHP's request for disenrollment shall include the following:

(a) If the member is enrolled in the PHP on the same day the member is admitted to the hospital, the PHP shall be responsible for said hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;

(b) The member has surgery scheduled at the time their enrollment is effective with the PHP, the provider is not on the

PHP's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the PHP;

(d) The member had End Stage Renal Disease at the time of enrollment in the PHP;

(e) Excluding the DCOs, if the PHP determines that the member has Third Party Liability (TPL), the PHP will contact the Health Insurance Group (HIG) to request disenrollment;

(f) If a PHP has knowledge of a member's change of address, the PHP shall notify the member's care team. The care team shall verify the address information and disenroll the member from the PHP, if the member no longer resides in the PHP's service area. Members shall be disenrolled if out of the PHP's service area for more than three months, unless previously arranged with the PHP. The effective date of disenrollment shall be the date specified by the Division and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the PHP;

(g) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the members and providing sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from PHPs for members who have been taken into custody;

(h) The member is in a state psychiatric institution.

(8) The Division has authority to initiate and disenroll members as follows:

(a) If informed that a member has a third party insurer (TPL), the Division shall refer the case to the HIG for investigation and possible exemption from PHP enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the PHP's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the PHP;

(c) If the member is no longer eligible for the Oregon Health Plan, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(9) Unless specified otherwise in these rules or in the Division notification of disenrollment to the PHP, all disenrollments are effective the end of the month the Authority approves the request with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated.

(b) The Authority may retroactively disenroll enrollment if the member has TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.645, 414.647

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 414.645, 414.647

REPEAL: 410-141-0120

RULE TITLE: Managed Care Prepaid Health Plan Provision of Health Care Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and ancillary services, and in those categories of services included in contract or agreements with the Division of Medical Assistance Programs (Division) and Addictions and Mental Health (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all participating providers providing covered services to Division members are credentialed upon initial contract with the PHP and recertified no less frequently than every three years thereafter. The credentialing and recertification process shall include review of any information in the National Practitioners Databank and a determination based on the requirements of the discipline or profession that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges, and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recertification Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 441.223. PHPs shall retain responsibility for delegated activities including oversight of the following processes:

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

(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, Oregon Health Plan (OHP) administrative rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and shall provide accurate and timely information about license or certification expiration and renewal dates to the Division. PHPs may not refer Division members to or use providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or certification is expired or not renewed or is subject to licensing or certification sanction, the PHP shall immediately notify the member's Provider Services Unit.

(D) PHPs may not refer members to or use providers who have been terminated from the Division or excluded as Medicare and Medicaid providers by Centers for Medicare and Medicaid (CMS) or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs may not accept billings for services to members provided after the date of such provider's exclusion, conviction, or termination. The Oregon Health Authority (Authority) has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they shall submit to their Coordinated Care Account Representative (CAR) for Authority approval prior to use. PHPs shall obtain information required on the appropriate disclosure form from individual practitioners and entities and shall retain the disclosure statements in the PHP credential files. If a PHP knows or has reason to know that a provider has been convicted of a felony or misdemeanor

related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of “nolo contendere”), the PHP shall immediately notify the Division’s Provider Services Unit.

(E) PHPs shall obtain and use the Division’s provider enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number “999999” may no longer be used in encounter data reporting or provider capacity reporting. PHPs shall require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).

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

(b) FCHPs, Physician Care Organization (PCOs), and Dental Care Organizations (DCOs) shall have written procedures that provide newly enrolled members with information about which participating providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, and DCOs shall have written procedures that allow and encourage a choice of a Primary Care Provider (PCP) or clinic for physical health and dental health services by each member. These procedures shall enable a member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that member;

(d) If the member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO shall ensure the member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign members to PCPs or clinics shall document the unsuccessful efforts to elicit the member’s choice before assigning a member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after enrollment shall notify the member of the assignment and allow the member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to the member’s satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded providers for payment of point-of-contact services in the following categories:

- (A) Immunizations;
- (B) Sexually transmitted diseases; and
- (C) Other communicable diseases.

(b) The following services may be received by Division members from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP’s or PCO’s referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), the member is responsible for payment of such services:

- (A) Family planning services; and
- (B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and

payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and planning committees;

(e) FCHPs and PCOs shall report to the Division on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled member receives timely, adequate, and appropriate health care services necessary to establish and maintain the health of the member. An FCHP's liability covers the period between the member's enrollment and disenrollment with the FCHP, unless the member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the member's PCP or designated practitioner determines the care is no longer medically appropriate.

(4) A PCO's liability covers the period between the member's enrollment and disenrollment with the PCO, unless the member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of the Division.

(5) The member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services and shall coordinate benefits for shared members to ensure that the member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible member is enrolled in a FCHP or PCO with a Medicare HMO component, the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health or dental care for that member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer members to the divisions of the Authority and local and regional allied agencies that may offer services not covered under the capitation payment;

(c) FCHPs and PCOs may not require members to obtain the approval of a PCP in order to gain access to mental health and Substance Use Disorder assessment and evaluation services. Division members may refer themselves to MHO services.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 414.727, 441.223

REPEAL: 410-141-0140

RULE TITLE: Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) PHPs shall have written policies and 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 Division members. PHPs 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 participating provider's compliance. PHPs shall document all monitoring and corrective action activities.
- (2) PHPs shall have written policies and procedures and monitoring processes to ensure that a practitioner provides a medically or dentally appropriate response as indicated to urgent or emergency calls consisting of the following elements:
 - (a) Telephone or face-to-face evaluation of the Division member to determine the nature of the situation and the Division member's immediate need for services;
 - (b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilizing the urgent or emergency situation;
 - (c) Development of a course of action at the conclusion of the assessment;
 - (d) Provision of services and/or referral needed to address the urgent or emergency situation, begin post-stabilization care or provide outreach services in the case of an MHO;
 - (e) Provision for notifying a referral emergency room, when applicable concerning the presenting problem of an arriving Division member, and whether or not the practitioner will meet the Division member at the emergency room; and
 - (f) Provision for notifying other providers requesting approval to treat Division members of the determination.
- (3) PHPs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from Division members. Urgent calls shall be returned appropriate to the Division 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 call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.
- (4) If a screening examination in an emergency room leads to a clinical determination by the examining physician that an actual emergency medical condition exists under the prudent layperson standard as defined in emergency services, the PHP must pay for all services required to stabilize the patient, except as otherwise provided in (6) of this rule. The PHP may not require prior authorization for emergency services:
 - (a) The PHP 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-emergency in nature;
 - (b) The PHP may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;
 - (c) The PHP may not deny a claim for emergency services merely because the Primary Care Physician (PCP) was not notified, or because the PHP was not billed within 10 calendar days of the service.
- (5) When a Division member's PCP, designated practitioner or other health plan representative instructs the Division member to seek emergency care, in or out of the network, the PHP is responsible for payment of the screening examination and for other medically appropriate services. Except as otherwise provided in (6) of this rule, the PHP is responsible for payment of post-stabilization care that was:

- (a) Pre-authorized by the PHP;
- (b) Not pre-authorized by the PHP if the PHP (or the on-call provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PHP or provider on call could not be contacted; or
- (c) If the PHP and the treating physician cannot reach an agreement concerning the Division member's care and a PHP representative is not available for consultation, the PHP must give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with care of the patient until a PHP physician is reached or one of the following criteria is met:
 - (A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;
 - (B) The participating provider assumes responsibility for the Division member's care through transfer;
 - (C) A contractor representative and the treating physician reach an agreement concerning the Division member's care;
 or
 - (D) The Division member is discharged.
- (6) PCO responsibility with regard to emergency services, urgent care services, or post-stabilization care services is as follows:
 - (a) A PCO is not financially responsible for emergency services, urgent care services, or post-stabilization care services, to the extent such services are inpatient hospital services. The PCO shall not authorize, cause, induce or otherwise furnish any incentive for emergency services, urgent care services, or post-stabilization care services to be rendered as inpatient hospital services except to the extent medically appropriate.
 - (b) A PCO is financially responsible for post-stabilization services (other than Inpatient hospital services) obtained by Division members within or outside the PCO's network under the following circumstances:
 - (A) Post-stabilization services have been authorized by the PCO's authorized representative;
 - (B) Post-stabilization services have not been authorized by the PCO's authorized representative, but are administered to maintain the Division member's stabilized condition within 1 hour of a request to the PCO's authorized representative for approval of further post-stabilization services;
 - (C) Post-stabilization services have not been authorized by the PCOs authorized representative, but are administered to maintain, improve, or resolve the Division member's stabilized condition if:
 - (i) The PCO's authorized representative does not respond to a request for authorization within 1 hour;
 - (ii) The PCO's authorized representative cannot be contacted; or
 - (iii) The PCO's authorized representative and the treating physician cannot reach an agreement concerning the Division member's care and the participating provider is not available for consultation. In this situation, the PCO must give the treating physician the opportunity to consult with the participating provider and the treating physician may continue with the care of the Division member until the participating provider is reached or one of the criteria in Section (6) of this rule has been met.
 - (c) The PCO's financial responsibility for non-inpatient post-stabilization services it has not approved ends when:
 - (A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;
 - (B) The participating provider assumes responsibility for the Division member's care through transfer;
 - (C) A PCO representative and the treating physician reach an agreement concerning the Division member's care; or
 - (D) The Division member is discharged.
 - (7) PHPs shall have methods for tracking inappropriate use of emergency care and shall take action, including individual Division member counseling, to improve appropriate use of urgent and emergency care settings. DCOs and MHOs shall be responsible for taking action to improve appropriate use of urgent and emergency care settings for dental or mental health related care when inappropriate use of emergency care is made known to them through reporting or other mechanisms.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0180

RULE TITLE: Oregon Health Plan Prepaid Health Plan Record Keeping

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Maintenance and Security: Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete clinical records that document the care received by the members from the PHP's primary care and referral providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's participating providers shall have written policies and procedures to ensure that clinical records related to the member's individual identifiable health information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50, and section (3) of this rule. If the PHP is a public body within the meaning of the Oregon public records law, the policies and procedures shall ensure that member privacy is maintained in accordance with 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their participating providers may not release or disclose any information concerning a member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the member;

(b) Except in an emergency, PHPs' participating providers shall obtain a written authorization for release of information from the member or the legal guardian or the member's legal Power of Attorney for Health Care Decisions before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information and shall be placed in the member's record. In an emergency, release of service information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the member;

(c) PHPs may consider a member age 14 or older competent to authorize or prevent disclosure of mental health and substance use disorder treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the member's clinical treatment requirements.

(3) Exchange of Protected Health Information for Treatment Purposes without Authorization: In accordance with ORS 192.518 to 192.526 and with required acknowledgement, the Authority and PHP's may share the following protected health information without member authorization for the purpose of treatment activities. The protected health information that may be disclosed, commonly found in claims or encounters, includes the following:

(a) Oregon Health Plan member name;

(b) Medicaid recipient number;

(c) Performing provider number;

(d) Hospital provider name and attending physician name;

(e) Diagnosis;

- (f) Dates of service;
- (g) Procedure code;
- (h) Revenue code;
- (i) Quantity of units of service provided;
- (j) Medication prescription and monitoring;
- (4) Access to clinical records:
 - (a) Provider access to clinical records:
 - (A) PHPs shall release health service information requested by a provider involved in the member's care within ten working days of receiving a signed authorization for release of information;
 - (B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service providers, have access to the applicable contents of a member's mental health record when necessary for use in the member's diagnosis or treatment. Such access is permitted under ORS 179.505(6);
 - (b) Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' participating providers shall upon request, provide the member access to their own clinical record, allow for the record to be amended or corrected, and provide copies within ten working days of the request. PHPs' participating providers may charge the member for reasonable duplication costs;
 - (c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' participating providers shall upon receipt of a member's written authorization for release of information, provide access to the member's clinical record. PHPs' participating providers may charge for reasonable duplication costs;
 - (d) Authority Access to Records: PHPs shall cooperate with the Division, the Addictions and Mental Health Division (AMH), the Medicaid Fraud Unit, and AMH representatives for the purposes of audits, inspection, and examination of members' clinical and administrative records.
 - (5) Retention of Records: All clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records shall be retained until all issues arising out of the action are resolved.
 - (6) Requirements for Clinical Records: PHPs shall have policies and procedures that ensure maintenance of a clinical record keeping system that is consistent with state and federal regulations to which the PHP is subject. The system shall assure accessibility, uniformity, and completeness of clinical information that fully documents the member's condition and the covered and non-covered services received from PHPs' participating or referred providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PHPs shall document all monitoring and corrective action activities:
 - (a) A clinical record shall be maintained for each member receiving services that documents all types of care needed or delivered in all settings whether services are delivered during or after normal clinic hours;
 - (b) All entries in the clinical record shall be signed and dated;
 - (c) Errors to the clinical record shall be corrected as follows:
 - (A) Incorrect data shall be crossed through with a single line;
 - (B) Correct and legible data shall be added followed by the date corrected and initials of the individual making the correction;
 - (C) Removal or obliteration of errors shall be prohibited;
 - (d) The clinical record shall reflect a signed and dated authorization for treatment for the member, his or her legal guardian, or the Power of Attorney for Health Care Decisions for any invasive treatments;
 - (e) The PCP's or clinic's clinical record shall include data that forms the basis of the diagnostic impression of the member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's member's clinical record receiving services shall include the following information as applicable:
 - (A) Member name, date of birth, sex, address, telephone number, and identifying number as applicable;

- (B) Name, address, and telephone number of next of kin, legal guardian, Power of Attorney for Health Care Decisions, or other responsible party;
- (C) Medical, dental, or psychosocial history as appropriate;
- (D) Dates of service;
- (E) Names and titles of individuals performing the services;
- (F) Physicians' orders;
- (G) Pertinent findings on examination and diagnosis;
- (H) Description of medical services provided including medications administered or prescribed; tests ordered or performed, and results;
- (I) Goods or supplies dispensed or prescribed;
- (J) Description of treatment given and progress made;
- (K) Recommendations for additional treatments or consultations;
- (L) Evidence of referrals and results of referrals;
- (M) Copies of the following documents if applicable:
 - (i) Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations, or evaluations;
 - (ii) Plans of care including evidence that the member was jointly involved in the development of the mental health treatment plan;
 - (iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;
 - (iv) Emergency department and screening services reports;
 - (v) Consultation reports;
 - (vi) Medical education and medical social services provided;
- (N) Copies of signed authorizations for release of information forms;
- (O) Copies of medical and mental health directives;
- (f) Based on written policies and procedures, the clinical record keeping system developed and maintained by PHPs' participating providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;
- (g) The PCP or clinic shall have policies and procedures that accommodate members requesting to review and correct or amend their clinical record;
- (h) PHPs' shall maintain other records in either the clinical record or within the PHP's administrative offices. Other records shall include the following:
 - (A) Names and phone numbers of the member's prepaid health plans, primary care physician or clinic, primary dentist, and mental health Practitioner, if any in the MHO records;
 - (B) Copies of Client Process Monitoring System (CPMS) also known as Measures and Outcomes Tracking System (MOTS) enrollment forms in the MHO's records;
 - (C) Copies of long-term psychiatric care determination request forms in the MHO's records;
 - (D) Evidence that the member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;
 - (E) Evidence that the member has been informed of his or her rights and responsibilities in the MHO records;
 - (F) ENCC records in the FCHP's or PCO's records;
 - (G) Complaint and Appeal records; and
 - (H) Disenrollment requests for cause and the supporting documentation.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0200

RULE TITLE: Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) QI Program:

(a) FCHPs, PCOs, DCOs and CDOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division members. This process shall include an internal Quality Improvement (QI) program based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with relevant law and the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards. The QI program shall include policies, standards, and written procedures that adequately address the needs of Division members, including those who are aged, blind or disabled who have complex medical needs; or children receiving CAF (SOSCF) or OYA services. FCHPs, PCOs, DCOs and CDOs shall establish or adopt written criteria to monitor and evaluate the provision of adequate medical and/or dental care. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(b) MHOs shall abide by the Quality Assurance Requirements as stated in the MHO Agreement.

(2) 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. FCHPs, PCOs, DCOs and CDOs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The Quality Improvement Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Division members including those who are aged, blind or disabled who have complex medical needs and children receiving CAF (SOSCF) or OYA services, or shall be able to retain consultation from individuals who are qualified.

(3) FCHPs, PCOs, DCOs and CDOs shall establish a QI Committee that shall meet at least every two months; The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:

(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings;

(b) Conduct and submit to the Division an annual written evaluation of the QI Program and of Division member care as measured against the written procedures and protocols of Division member care. The evaluation of the QI program and Division member care is to include a description of completed and ongoing QI activities, Division member education and an evaluation of the overall effectiveness of the QI program. This evaluation shall include:

(A) Prevention programs;

(B) Care of Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services, and FCHP or PCO review of the Quality of Exceptional Needs Care Coordination program;

(C) Disease management programs;

(D) Adverse outcomes of Division members and Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services;

(E) Actions taken by the FCHPs, PCOs, DCOs or CDOs to address health care concerns identified by Division members or their Representatives and changes which impact quality or access to care. This may include: clinical record keeping; utilization review; referrals; comorbidities; prior authorizations; Emergency Services; out of FCHPs, PCOs, DCOs or CDOs utilization; medication review; FCHPs, PCOs, DCOs or CDOs initiated disenrollments; encounter data management; and access to care and services.

(c) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant Division member complaints and appeals;

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

(4) FCHPs or PCOs that are NCQA accredited or accredited by other Division recognized accreditation organizations shall be deemed for Section (3)(b) of this rule. FCHPs and PCOs deemed by the Division shall annually submit to the Division an evaluation of the Exceptional Needs Care Coordination program; and an evaluation of Division member care for Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services. Copies of accreditation reports shall be submitted to the Division within 60 days of issuance.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0220

RULE TITLE: Managed Care Prepaid Health Plan Accessibility

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all members. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure participating provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between members and non-members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures that ensure for 90 percent of their members in each service area, routine travel time or distance to the location of the PCP does not exceed the community standard for accessing health care participating providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by the Division:

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

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

(b) PHPs shall maintain and monitor a network of appropriate participating providers sufficient to ensure adequate service capacity to provide availability of and timely access to medically appropriate covered services for members:

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

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision, and ancillary services as accessible to members in terms of timeliness, amount, duration, and scope as those services are to non-members within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to the Division and shall provide reasonable alternatives for members to access care that must be approved by the Division. PHPs shall demonstrate to the Division that it surveys and monitors for equal access of member referrals to provider, pharmacy, hospital, vision, and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled who have complex medical needs or who are children receiving CAF (SOSCF services) or OYA services have access to primary care, dental care, mental health providers, and referral, as applicable. These providers shall have the expertise to treat, take into account, and accommodate the full range of medical, dental, or mental health conditions experienced by these members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs enrollment standards:

(a) PHPs shall remain open for enrollment unless the Authority has closed enrollment because the PHP has exceeded their enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by the Division and the PHP;

(b) PHPs enrollment may also be closed by the Division due to sanction provisions;

(c) PHPs shall accept all clients, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Division to provide covered services;

(d) PHPs 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 Division;
 - (B) The individual presents a valid medical care identification that shows he or she is enrolled with the PHP;
 - (C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the PHP;
 - (D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the PHP.
- (e) PHPs shall have open enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.
- (3) If a PHP is assumed by another PHP, members shall be automatically enrolled in the succeeding PHP. The member will have 30 calendar days to request disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding PHP.
- (4) If a PHP engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area and necessitates either transferring members to other providers or the PHP withdrawing from part or all of a service area, the PHP shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:
- (a) A PHP may provide less than the required 90 calendar-day notice to the Authority upon approval by the Authority when the PHP 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 PHP and refuses to provide the required 90 calendar-day notice;
 - (b) If DHS must notify members of a change in participating providers or PHPs, the PHP shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide members with at least a 30 calendar-day notice of such changes.
- (5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit:
- (a) PHPs shall have written policies and procedures and a monitoring system to assure that members have access to appointments according to the following standards:
 - (A) FCHPs and PCOs:
 - (i) Emergency Care: The member shall be seen immediately or referred to an emergency department depending on the member's condition;
 - (ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening, in accordance with OAR 410-141-0140; and
 - (iii) Well Care: The member shall be seen within four weeks or within the community standard.
 - (B) DCOs:
 - (i) Emergency Care: The member shall be seen or treated within 24-hours;
 - (ii) Urgent Care: The member shall be seen within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and
 - (iii) Routine Care: The member shall be seen for routine care within an average of eight weeks and within twelve weeks or the community standard, whichever is less, unless there is a documented special clinical reason that would make access longer than 12 weeks appropriate.
 - (C) MHOs:
 - (i) Emergency Care: The member shall be seen within 24-hours or as indicated in initial screening;
 - (ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening;
 - (iii) Non-Urgent Care: The member shall be seen for an intake assessment within two weeks from date of request.
 - (b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of members through the office such that members are not kept waiting longer than non- member patients under normal

circumstances. If members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through complaint and appeal reviews, termination reports, and member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with members when participating providers have notified the PHP that the members have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed medically or dentally appropriate, documentation in the clinical record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. 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 PHP's participating provider office or clinic, PHPs shall provide outreach services as medically appropriate;

(d) PHPs shall have policies and procedures that ensure participating providers will attempt to contact members if there is a need to cancel or reschedule the member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to triage the service needs of members who walk into the PCP's office or clinic with medical, mental health, or dental care needs. Such triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the member's needs or be evaluated for treatment within two hours by a medical, mental health, or dental provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by the Division because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate clinical record of the Division member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental provider must be consulted. When medically appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the Division member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's participating providers) have sufficient communication skills and training to reassure members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's quality improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult

available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health, or dental care visits including home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to be able to understand the member's complaint, to make a diagnosis, to respond to the member's questions and concerns, and to communicate instructions to the member;

(c) PHPs shall ensure the provision of care and interpreter services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the member;

(d) PHPs shall have written policies and procedures that ensure compliance 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 referral providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether members are receiving accommodations for access and to determine what will be done to remove existing barriers and to accommodate the needs of members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all members including, but not limited to, the following:

(i) Street level access or accessible ramp into the facility;

(ii) Wheelchair access to the lavatory;

(iii) Wheelchair access to the examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that participating providers, their facilities, and personnel are prepared to meet the complex medical needs of members who are aged, blind, or disabled:

(A) PHPs shall have a written plan for meeting the complex medical needs of members who are aged, blind, or disabled;

(B) PHPs shall monitor participating providers for compliance with the access plan and take corrective action when necessary.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0270

RULE TITLE: Prepaid Health Plan Marketing Requirements for Potential Members

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(a) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the PHP; Cold-call marketing methodologies may include, but are not limited to, door to door, telephone, mail, or e-mail.

(b) "Marketing" means any communication from a PHP to a potential member who is not enrolled in the PHP that can reasonably be interpreted as intended to compel or entice the potential members to enroll in that particular PHP;

(c) "Marketing Materials" means materials that are produced in any medium by or on behalf of a PHP and that can reasonably be interpreted as intended to market to potential members;

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

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

(f) "Potential Member" means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP.

(2) PHPs must comply with the information required in 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the PHP provides accurate oral and written information a potential member needs to make an informed decision on whether to enroll in that PHP. In so doing, the PHP must:

(a) Not distribute any marketing materials without first obtaining state approval;

(b) Distribute the materials to its entire service area as indicated in its PHP contract;

(c) Not seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance;

(d) Not directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The creation of name recognition shall not constitute an attempt by the PHP to compel or entice a client's enrollment and are expressly permitted. Communication methodologies may include, but are not limited to: brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

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

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

(6) PHPs have sole accountability for producing or distributing materials following OHA approval.

(7) PHPs shall comply with the Authority marketing materials submission guidelines. PHPs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

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

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

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

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

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

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0320

RULE TITLE: Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure Division of Medical Assistance Programs (Division) members have the rights and responsibilities included in this rule:

(a) PHPs shall communicate these policies and procedures to participating providers;

(b) PHPs shall monitor compliance with policies and procedures governing member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) The members shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by participating providers the same as other people seeking health care benefits to which they are entitled;

(c) To choose a PHP as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;

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

(f) To be actively involved in the development of the member's treatment plan;

(g) To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;

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

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

(j) To have written materials explained in a manner that is understandable to the member;

(k) To receive necessary and reasonable services to diagnose the presenting condition;

(l) To receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and is medically appropriate;

(m) To obtain covered preventive services;

(n) To have access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(o) To receive a referral to specialty practitioners for medically appropriate covered services;

(p) To have a clinical record maintained that documents conditions, services received, and referrals made;

(q) To have access to one's own clinical record unless restricted by statute;

(r) To transfer a copy of the member's clinical record to another provider;

(s) To execute a statement of wishes for treatment including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 — Patient Self-Determination Act;

- (t) To receive written notices before a denial of or change in a benefit or service level is made unless such notice is not required by federal or state regulations;
 - (u) To know how to make a complaint or appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-141-0266;
 - (v) To request an administrative hearing with the Authority;
 - (w) To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and
 - (x) To receive a notice of an appointment cancellation in a timely manner.
- (3) The member shall have the following responsibilities:
- (a) To choose or help with assignment to a PHP as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements and a PCP or service site;
 - (b) To treat the PHP, practitioner, and clinic staff with respect;
 - (c) To be on time for appointments made with practitioners and other providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;
 - (d) To seek periodic health exams and preventive services from a PCP or clinic;
 - (e) To use a PCP or clinic for diagnostic and other care except in an emergency;
 - (f) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
 - (g) To use urgent and emergency services appropriately and notify the PHP within 72 hours of an emergency;
 - (h) To give accurate information for inclusion in the clinical record;
 - (i) To help the practitioner, provider, or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
 - (j) To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;
 - (k) To use information to make informed decisions about treatment before it is given;
 - (L) To help in the creation of a treatment plan with the provider;
 - (m) To follow prescribed, agreed upon treatment plans;
 - (n) To tell the practitioner or provider that the member's health care is covered under OHP before services are received and, if requested, to show the practitioner or other provider the Division Medical Care Identification form;
 - (o) To tell the Authority worker of a change of address or phone number;
 - (p) To tell the Authority worker if the member becomes pregnant and to notify the Authority worker of the birth of the member's child;
 - (q) To tell the Authority worker if any family members move in or out of the household;
 - (r) To tell the Authority worker if there is any other insurance available;
 - (s) To pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
 - (t) To pay the monthly OHP premium on time if so required;
 - (u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;
 - (v) To bring issues or complaints or grievances to the attention of the PHP; and
 - (w) To sign an authorization for release of medical information so that the Authority and the PHP can get information that is pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0340

RULE TITLE: Oregon Health Plan Managed Care Entity Financial Solvency

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Managed Care Entities (MCEs) shall assume the risk for providing capitated services under their contracts and agreements with the Oregon Health Authority (Authority). MCEs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division:

(a) MCEs shall comply with solvency requirements specified in contracts and agreements with the Authority. Solvency requirements of MCEs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts and agreements with the Authority. If the MCE has contracts and agreements with the Authority, separate restricted reserve fund accounts shall be maintained for each contract and agreement. The Authority does not require separate restricted reserve accounts for the Cover All Kids and Oregon Health Plan contracts; however, adequate reserve levels need to be maintained when reviewing both contracts in aggregate;

(B) Protection against catastrophic and unexpected expenses related to capitated services for MCEs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance, or any other alternative determined acceptable by the Authority. Self-insurance must be determined appropriate by the Authority;

(C) Maintenance of professional liability coverage of not less than \$1,000,000 per person per incident and not less than \$1,000,000 in the aggregate either through binder issued by an insurance carrier or by self-insurance with proof of same, except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;

(D) Systems that capture, compile, and evaluate information and data concerning financial operations. Such systems shall provide for the following:

(i) Determination of future budget requirements for the next three quarters;

(ii) Determination of incurred but not reported (IBNR) expenses;

(iii) Tracking additions and deletions of members and accounting for capitation payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of members; and

(vi) Documentation of and reports on the use of incentive payment mechanisms, risk-sharing, and risk-pooling, if applicable.

(b) MCEs shall submit the following applicable reports as specified in agreements with the Division:

(A) An annual audit performed by an independent accounting firm containing but not limited to:

(i) A written statement of opinion by the independent accounting firm based on the firm's audit regarding the MCE's financial statements;

(ii) A written statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities, and related items;

(iii) Balance Sheets;

(iv) Statement of Revenue, Expenses and Net Income, and Change in Fund Balance;

(v) Statements of Cash Flows;

(vi) Notes to Financial Statements;

(vii) Health Related Services (as defined by OAR 410-141-3150 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;

(viii) Any supplemental information deemed necessary by the independent accounting firm or actuary;

(ix) Certification of compliance with financial and encounter data reporting requirements; and

(x) Any supplemental information deemed necessary by the Authority.

(B) MCE-specific quarterly financial reports. Such quarterly reports shall include but are not limited to:

(i) Statement of Revenue, Expenses and Net Income;

(ii) Balance Sheet;

(iii) Statement of Cash Flows;

(iv) Incurred But Not Reported (IBNR) Expenses;

(v) Fee-for-service liabilities and medical and hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (MCE contractor);

(viii) Certification of compliance with financial and encounter data reporting requirements; and

(ix) Corporate Relationships of Contractors (FCHPs, DCOs, and PCOs) or Incentive Plan Disclosure and Detail (MCEs).

(C) MCE-specific utilization reports;

(D) MCE-specific quarterly documentation of the Restricted Reserve. Restricted reserve funds of FCHPs, PCOs, and DCOs shall be held by a third party. Restricted reserve fund documentation shall include the following:

(i) A copy of the certificate of deposit from the party holding the restricted reserve funds;

(ii) A statement showing the level of funds deposited in the restricted reserve fund accounts;

(iii) Documentation of the liability that would be owed to creditors in the event of MCE insolvency;

(iv) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.

(c) MCEs that sub-capitate any work described in agreements with the Division shall require subcontractors to report financial activity at the sub-capitated entity level as specified in agreements with the Division:

(A) "Sub-capitated Entity" means an individual or organization affiliated with the MCE who is authorized to provide services to members or any other risk accepting entity receiving a sub-capitation payment from an MCE as a payment for services provided to members;

(B) MCEs that pay annual sub-capitation payments in the amount greater than 0.5 percent of an MCE's annual gross revenues shall submit to the division the following sub-capitated entity financial reports on an annual basis including but not limited to:

(i) Statement of Revenue, Expenses and Net Income;

(ii) Restricted reserve documentation;

(iii) Certification of compliance with financial and encounter data reporting requirements;

(iv) Any supplemental information deemed necessary by the Division.

(2) MCEs shall comply with the following additional requirements regarding restricted reserve funds:

(a) MCEs that sub-capitate any work described in agreements with the Authority may require subcontractors to maintain a restricted reserve fund for the subcontractor's portion of the risk assumed or may maintain a restricted reserve fund for all risk assumed under the agreement with the Authority. Regardless of the alternative selected, MCEs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with the Authority;

(b) If the restricted reserve fund of the MCE is held in a combined account or pool with other entities, the MCE and its subcontractors, as applicable, shall provide a statement from the pool or account manager that the restricted reserve fund is available to the MCE or its subcontractors, as applicable, and is not obligated elsewhere;

(c) If the MCE must use its restricted reserve fund to cover services under its agreement with the Authority, the MCE shall provide advance notice to the Authority of the amount to be withdrawn, the reason for withdrawal, when and how the restricted reserve fund will be replenished, and steps to be taken to avoid the need for future restricted reserve fund withdrawals;

(d) MCEs shall provide the Authority access to restricted reserve funds if insolvency occurs;

- (e) MCEs shall have written policies and procedures to ensure that if insolvency occurs, members and related clinical records are transitioned to other MCEs or providers with minimal disruption.
- (3) The Authority may require an MCE to produce books, records, accounts, papers, documents, and computer and other recordings the MCE or the MCE's affiliates have that are necessary for the Authority to ascertain the MCE's financial condition or to determine the MCE's compliance with the contracts and agreements with the Authority.
- (4) Funds of an MCE may be invested in a bond, debenture, note, warrant, certificate, or other evidence of indebtedness that are not investment grade as established by these rules, but the funds that a MCE may invest under this section shall not exceed 20 percent of the MCE's assets. For purposes of this rule, MCEs shall be subject to the requirements of OAR 836-033-0105 through 836-033-0130.
- (5) An MCE may not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the MCE's assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This section does not apply to:
- (a) Investments in or loans upon the security of the general obligations of a sovereign; or
 - (b) Investments by an MCE in all real or personal property used exclusively by such MCE to provide health services or in real property used primarily for its home office.
- (6) MCEs shall comply with the following additional requirements regarding Health Related Services (as defined by OAR 410-141-3150 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 Non-Encounterable Service Costs in the Minimum Medical Loss Rebate Calculation report.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0400

RULE TITLE: Oregon Health Plan Prepaid Health Plan Case Management Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

DCO: Dental Care Organization

FCHP: Fully Capitated Health Plan

MHO: Mental Health Organization

OHP: Oregon Health Plan

PCO: Physician Care Organization

PHP: Prepaid Health Plan

(1) Prepaid health plans provide case management services under the Oregon Health Plan.

(2) Prepaid Health Plan case management services are defined as follows:

(a) FCHPs and PCOs provide medical case management as defined in OAR 410-141-0000, Definitions;

(b) DCOs provide dental case management as defined in OAR 410-141-0000, Definitions. DCOs shall make dental case management staff available for training, Regional OHP meetings, and case conferences involving their Division members in all service areas;

(c) MHOs provide mental health case management for capitated and non-capitated mental health services as defined in OAR 410-141-0000, Definitions.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0405

RULE TITLE: Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination (ENCC)

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

Division may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule. Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

- (1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all capitated services;
- (2) FCHPs and PCOs shall make ENCC services available to Division members (see definition) or Division member's representative (see definition) identified as aged, blind or disabled who have complex medical needs at the request of a Division member or Division member's representative, a physician, other medical personnel serving the Division member, or the Division member's agency case manager;
- (3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving Division members or Division member's representative identified as aged, blind or disabled who have complex medical needs in all their service areas;
- (4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are aged, blind, disabled or who have complex medical needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;
- (5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;
- (6) FCHPs and PCOs shall make ENCC services available to Division members identified as aged, blind or disabled who have complex medical needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to a Division member's representative during normal business hours, Monday through Friday;
- (7) FCHPs and PCOs shall provide the aged, blind or disabled who have complex medical needs Division member or Division member's representative who requests ENCC services with an initial response by the next working day following the request, as appropriate;
- (8) FCHPs and PCOs shall periodically inform all of their practitioners (see definition) and the practitioner's staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving the aged, blind, disabled or who have complex medical needs Division members or Division member's representative; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and Division members or Division member's representative;
- (9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;
- (10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of covered services to aged, blind or disabled who have complex medical needs to Division members or Division member's representative who exhibit inappropriate, disruptive or threatening behaviors in a practitioner's office;
- (11) Exceptional Needs Care Coordinators shall document ENCC services in Division member medical records as appropriate and/or in a separate Division member case file.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0407

RULE TITLE: Oregon Health Plan Ombudsman Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The Authority provides ombudsman services to all Division members who are aged, blind or disabled who have complex medical needs as defined in OAR 410-141-0000, Definitions.

(2) The Authority shall inform all Division members who are aged, blind or disabled who have complex medical needs of the availability of ombudsman services.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

REPEAL: 410-141-0440

RULE TITLE: Prepaid Health Plan Hospital Contract Dispute Resolution

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

When there is a failure to reach agreement on a contract between a Fully Capitated Health Plan (FCHP) or a Physician Care Organization (PCO) and a non Type A, Type B, or critical access hospital, the two disagreeing parties must engage in non-binding mediation. This requirement to engage in non-binding mediation does not apply to disagreements involving emergency or urgent services as defined in Oregon Health Plan administrative rules. The hospital, FCHP, or the PCO can call for mediation. If the parties agree on a mediator their selection shall stand. If a mediator cannot be mutually agreed on, the State will make the selection from the recommended names forwarded by each party. The cost of mediation will be evenly split between the FCHP or PCO and the hospital.

(1) The mediation will proceed under the following guidelines:

- (a) Access to care for OHP members is of critical importance;
- (b) Any agreement must operate within the capitation rate received by the FCHP or PCO;
- (c) Reimbursement levels must bear some relationship to the cost of the services;
- (d) Consideration shall be given to the efforts of each part to manage the overall utilization of health care resources and control costs;
- (e) A comparison to statewide averages of each party's cost of services, service utilization rates and administrative costs may be considered in reaching a mediation recommendation.

(2) No client medical information, communication between parties, nor any other non public information used in the mediation may be disclosed to any person not a party to the mediation. All such information shall not be admissible nor disclosed in any subsequent administrative, judicial or mediation proceeding.

(3) Within thirty (30) days of the conclusion of the mediation, the mediator will issue a report to the State and to the involved parties that will include mediation findings, and recommendations. All confidential information will be excluded from the mediator's report.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0480

RULE TITLE: Oregon Health Plan Benefit Package of Covered Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) Division members are eligible to receive, subject to section (11) of this rule, those treatments for the condition/treatment pairs funded on the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are medically or dentally appropriate, except that services shall also meet the prudent layperson standard defined in 410-141-0140. Refer to 410-141-0520 for funded line coverage information.
- (2) Medical Assistance Benefit Packages follow practice guidelines adopted by the HERC in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.
- (3) Diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services regardless of the placement of the condition on the Prioritized List of Health Services.
- (4) Comfort care is a covered service for a member with a terminal illness.
- (5) Preventive services promoting health and reducing the risk of disease or illness are covered services for members. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors (See OAR 410-141-0520 Prioritized List of Health Services).
- (6) Ancillary services are covered subject to the service limitations of the OHP program rules when the services are medically or dentally appropriate for the treatment of a covered condition/treatment pair, or the provision of ancillary services will enable the member to retain or attain the capability for independence or self-care.
- (7) The provision of SUD services shall comply with Addictions and Mental Health Division (AMH) administrative rules, OAR 415-012-0000 "Standards for Approval/Licensure of Alcohol and Other Drug Abuse Programs," OAR 415-020 "Standards for Outpatient Synthetic Opiate Treatment Programs," OAR 415-050 "Standards for Alcohol Detoxification Centers," OAR 309-018 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services," OAR 309-019 "Outpatient Addictions and Mental Health Services," OAR 309-022 "Intensive Treatment Services for Children and Adolescents and Children's Emergency Safety Intervention Specialist," and the requirements in the SUD subsection of the Statement of Work in the CCO and PCO contracts.
- (8) In addition to the coverage available under section (1) of this rule, a member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:
 - (a) Services may be provided if it can be shown that:
 - (A) The OHP member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and
 - (B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and
 - (C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;
 - (D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;
 - (E) Any unfunded or funded co-morbid conditions or disabilities shall be represented by an ICD-10-CM diagnosis code or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity; and
 - (F) In order for the treatment to be covered, there shall be a medical determination and finding by the Division for fee-

for-service OHP clients or a finding by the Prepaid Health Plan (PHP) for members that the terms of subsection (a)(A)–(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any member, especially a member with a disability or with a co-morbid condition, providers shall determine whether the member has a funded condition/treatment pair that would entitle the member to treatment under the program, and both the funded and unfunded conditions shall be represented by an ICD- 10-CM diagnosis code, or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity.

(9) The Division shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the OHP Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Division shall make a retrospective determination under this section, provided the Division is notified of the emergency situation during the next business day. If the Division denies a requested service, the Division shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the HERC Prioritized List of Health Services and the Division determines the condition/treatment pair has not been identified by the HERC for inclusion on the list, the Division shall make a coverage decision in consultation with the HERC.

(11) Coverage of services available through the OHP Benefit Package of Covered Services is limited by OAR 410-141-0500 (Excluded Services and Limitations for Oregon Health Plan Clients).

(12) General anesthesia for dental procedures that are medically and dentally appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0500

RULE TITLE: Excluded Services and Limitations for Oregon Health Plan clients and/or Division members

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are excluded under the Division shall be excluded under the Oregon Health Plan (OHP);

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the OHP administrative rules;

(c) Any treatment, service, or item for a condition that is not included on the funded lines of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the OHP client's and/or Division member's OHP benefit package, are excluded;

(e) Any treatment, service, or item for a condition which is listed as a Condition/Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or non-covered condition/treatment pair;

(g) Services requested by OHP clients and/or Division member's in an emergency care setting which after a screening examination are determined not to meet the definition of emergency services and the provisions of 410-141-0140;

(h) Services provided to an OHP client and/or Division member outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(i) Services or items, other than inpatient care, provided to an OHP client and/or Division member who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(j) Services received while the Division member is outside the contractor's service area that were either:

(A) Not authorized by the Division member's primary care provider; or

(B) Not urgent or emergency services, subject to the Division member's appeal rights, that the Division member was outside contractor's service area because of circumstances beyond the Division member's control. Factors to be considered include but are not limited to death of a family member outside of contractor's service area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are medically appropriate to provide reasonable diagnosis and treatment or to enable the OHP client to attain or retain the capability for independence or self-care. Included would be those services which upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the OHP Prioritized List of Health Services;

(c) Services that are limited under the Division as identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are limited under the Division shall be limited under the OHP.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that OHP clients are informed of:

(a) Clinically appropriate treatment that may exist, whether covered or not;

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-0520

RULE TITLE: Prioritized List of Health Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and behavioral health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their website: <https://www.oregon.gov/OHA/HPA/DSI-HERC/Pages/Prioritized-List.aspx>. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule, effective October 1, 2019, incorporates by reference new interim modifications to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2018–December 31, 2019, Prioritized List funded through line 469. This amended Prioritized List includes revised line items and new/revised guideline notes, statements of intent, coding specifications, and annotations that supersede those found in the January 1, 2019, Prioritized List.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065, ORS 414.727

REPEAL: 410-141-0860

RULE TITLE: Oregon Health Plan Patient Centered Primary Care Home Provider Qualification and Enrollment

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

CCOs shall administer the Patient Centered Primary Care Home program and receive program required reporting as supposed by OAR 409-055-0000 through 409-055-0090 and the 2016 CCO contract.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065;

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-3000

RULE TITLE: Managed Care Entity Definitions

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) The Oregon Health Authority adopts and incorporates by reference the definitions below for use by the Managed Care Entities in the following administrative rules and applies them to Health System Transformation:
- (a) OAR 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;
- (b) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and
- (c) OAR 410-141-3000.
- (2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the coordinated care contracts in the context of hearings and appeals.
- (3) "Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service. See OAR 410-141-3240 for a member enrolled in an MCE.
- (4) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.
- (5) "Applicant" means the entity submitting an application to be a CCO or to enter into or amend a contract for coordinated care services.
- (6) "Application" means an entity's written response to a Request for Application (RFA).
- (7) "Auxiliary Aids and Services" means services available to members as defined in CMS Section 1557 of the ACA.
- (8) "Award Date" means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts.
- (9) "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 a PHP agrees to provide for a capitation payment under contract with the Authority.
- (12) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.
- (13) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.
- (14) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.
- (15) "Cold Call Marketing" means an MCE's unsolicited personal contact, including texting and email, with a potential member for marketing.
- (16) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is

addressing the health care needs of CCO members and the community consistent with ORS 414.625.

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

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

(19) "Contract Renewal" means an agreement by a CCO to amend the terms or conditions of an existing contract for the next benefit period.

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

(21) "Coordinated Care Services" mean an MCE's fully integrated physical health, behavioral health services, and oral health services.

(22) "Corrective Action or Corrective Action Plan" means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

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

(24) "Dental Case Management Services" means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(25) "DCBS Reporting CCO" means a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

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

(27) "Disenrollment" means the act of removing a member from enrollment with an MCE.

(28) "Exceptional Needs Care Coordination (ENCC)" means for PHPs a specialized case management service provided to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.

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

(30) "Entity" means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization.

(31) "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.

(32) "Grievance System" means the overall system that includes:

(a) Grievances to an MCE on matters other than actions;

(b) Appeals to an MCE on actions; and

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

(33) "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.

(34) "Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being. Health-related services include flexible

services and community benefit initiatives. Flexible services are cost-effective services offered to an individual member to supplement covered benefits. Community benefit initiatives are community-level interventions that include but are not necessarily limited to members and are focused on improving population health and health care quality:

(a) The goals of health-related services are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to billable office visits and are often cost-effective services offered as an adjunct to covered benefits. Health-related services lack traditional billing or encounter codes, are not encounterable, and may not be reported for utilization purposes;

(b) To be considered a health-related service, a service must meet the requirements for:

(A) Activities that improve health care quality as defined in 45 CFR 158.150; or

(B) Expenditures related to Health Information Technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.

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

(36) "Home CCO" means enrollment in a CCO in a service area based upon a client's most recent permanent residency, determined at the time of original eligibility or most current point of CCO enrollment prior to hospitalization.

(37) "Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12 and:

(a) Is a member of a federally recognized Indian tribe;

(b) Resides in an urban center and meets one or more of the four criteria;

(c) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside or who is a descendant in the first or second degree of any such member:

(A) Is an Eskimo or Aleut or other Alaska Native;

(B) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(C) Is determined to be an Indian under regulations issued by the Secretary:

(i) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(ii) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

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

(39) "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.

(40) "Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.

(41) "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.

(42) "Limited English Proficient (LEP)" means potential members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a service, benefit, or encounter.

(43) "Line Items" means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

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

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

(46) "Medicaid-funded Long-term Care or Long-term Services and Supports" means all Medicaid funded services CMS defines as long-term services and supports that include both:

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

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

(47) "Medical Case Management Services" means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

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

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

(50) "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.

(51) "Net Premium" means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

(52) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.

(53) "Oregon Health Authority or Authority Reporting MCE" means an MCE that reports its solvency plan and financial status to the Authority under these rules.

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

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

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

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

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

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

(58) "Request for Applications (RFA)" means the document used for soliciting applications for a CCO, award of or

amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.

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

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

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3010

RULE TITLE: CCO Application and Contracting Procedures

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) The Authority shall establish an application process for entities seeking contracts as CCOs.
- (2) The Authority shall use the following RFA processes for CCO procurement and contracting:
 - (a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants are made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;
 - (b) The RFA process shall begin with a public notice that shall be communicated using the Oregon Procurement Information Network (ORPIN) website. A public notice of an RFA shall identify the services the Authority is seeking, the designated service areas where services are requested, a sample contract, and how potential applicants can keep informed of RFA updates;
 - (c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;
 - (d) The RFA may request applicants to appear at a public meeting to provide information about the application;
 - (e) The RFA shall request information from applicants to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;
 - (f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require electronic submission of the application in accordance with OAR 137-047-0330, Electronic Procurements. If an electronic procurement process is used, applications shall be accepted only from applicants who accept the terms and conditions of the electronic method being used for application submission.
- (3) Readiness Reviews:
 - (a) The Authority shall have discretion whether to have a readiness review process unless otherwise required by law and require successful completion of the readiness review as a condition to contracting;
 - (b) If the Authority chooses to have a readiness review process and require successful completion as a condition to contracting, the process shall be described in the underlying procurement document or otherwise communicated to respondents during the procurement process;
 - (c) Readiness review shall include those areas required by law and may also include other topics identified by the Authority;
 - (d) The Authority reserves the right to request to provide updated information gleaned during the readiness review process throughout the term of the resulting contract as needed for compliance monitoring and performance reviews.
- (4) The Authority shall determine that organizations meet the criteria for being CCOs as follows:
 - (a) The Authority shall evaluate applications for being a CCO based on criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;
 - (b) The Authority shall notify each applicant that applies for CCO status if it meets the criteria for being a CCO;
 - (c) The Authority shall issue CCO contracts only to applicants that meet the criteria in OAR 410-141-3015, meet the RFA requirements, and provide the assurances specified in the RFA. The Authority shall determine if the applicant

qualifies for being a CCO based on the application and any additional information and investigation that the Authority may require;

(d) The Authority determines an applicant is eligible for a CCO contract when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:

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

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

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

(D) Shall comply with any assurances it gives the Authority.

(e) The Authority may determine that an applicant is potentially eligible for a CCO contract in accordance with paragraph (f) below. The Authority is not obligated to determine whether an applicant is potentially eligible for a CCO contract if, in its discretion, the Authority determines that sufficient applicants eligible for a CCO contract are available to attain the Authority's objectives under the RFA;

(f) The Authority may determine that an applicant is potentially eligible for a CCO contract if:

(A) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period; and

(B) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for a CCO contract. The Authority shall determine the date and required documentation and written assurances required from the applicant;

(C) If the Authority determines that an applicant potentially eligible for a CCO contract does not meet the criteria for a CCO contract within the time announced in the RFA for contract award, the Authority may:

(i) Offer a CCO contract at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for a CCO contract within the scope of the RFA; or

(ii) Inform the applicant that it is not eligible for a CCO contract.

(g) The Authority shall enter into a new contract or contract renewal with a CCO only if the CCO meets the criteria for being a CCO and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes but is not limited to:

(A) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda; and

(B) The number of CCOs in the region.

(5) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:

(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(b) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;

(c) The Authority may award multiple contracts or make a single award or limited number of awards to meet the Authority's needs, including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA; and

(d) Subject to any limitations in the RFA, the Authority may execute a contract renewal for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA.

(6) Disclosure of application contents and release of information:

(a) Except for the letter of intent to apply, information may not be disclosed to any applicant or the public until the award date, unless otherwise specified in the RFA and allowed by law. No information may be given to any applicant or

the public relative to its standing with other applicants before the award date except under the following circumstances:

(A) The information in the application may be shared with the Authority, DCBS, Oregon Health Insurance Marketplace, PEBB, OEBS, PERS, CMS, and those individuals involved in the application review and evaluation process; and

(B) Information may be provided by the applicant to the public as part of a public review process.

(b) Application information may be disclosed on the award date, except for information that has been clearly identified and labeled confidential in the manner specified in the RFA if the Authority determines it meets the disclosure exemption requirements.

(7) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts funded by federal funds.

(8) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on June 30, 2018) to govern RFAs and contracting with CCOs:

(a) General Provisions Related to Public Contracting: OARs 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;

(b) Public Procurements for Goods or Services: OARs 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and 137-047-0800;

(c) In applying the DOJ Model Rules to RFAs under this rule:

(A) An application is a proposal under the DOJ Model Rules;

(B) An RFA is an RFP under the DOJ Model Rules;

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules if the Authority requires certification as a condition to contract;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are incorporated herein;

(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.

(9) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3015

RULE TITLE: Criteria for Coordinated Care Organizations

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

Pursuant to OAR 410-141-3010, the Authority may include a readiness review process as part of the RFA and require successful completion of the readiness review process as a condition to contracting.

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO contracting within the context of the Oregon Health Policy Board's adopted reports and policies.

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above \$250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers, and where possible choice among CCOs;

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

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

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

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

(b) Each criterion is listed followed by the elements that are addressed during the initial evaluation described in this rule without limiting the information that is requested in the RFA.

(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:

(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria 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 DHS Medicaid-funded, long-term care services and supports.

(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC 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.

(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:

(a) Since community health assessments 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.

(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.

(10) Dental care organizations: Each CCO shall have a contractual relationship with any DCO in its service area.

(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:

(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;

(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.

(12) CCOs shall provide integrated, personcentered care and services designed to provide choice, independence, and dignity. The applicant shall describe its strategy:

(a) To assure that each member receives integrated, personcentered 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.

(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall 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.

(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:

- (a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;
- (b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.

(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:

- (a) Work together to develop best practices for care and service delivery to reduce waste and improve health and wellbeing of all members;
- (b) Be educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;
- (c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;
- (d) Be permitted to participate in the networks of multiple CCOs;
- (e) Include providers of specialty care;
- (f) Be selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards;
- (g) Establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in alignment with contractual requirements;
- (h) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and mobile crisis services, Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization, and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;
- (i) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.

(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

- (a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;
- (b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate followup care when entering or leaving an acute care facility or long-term care setting 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.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists, peer-delivered services specialists, and community health workers.

(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

- (a) Delivery system elements that respond to member needs for access to coordinated care services and supports;
- (b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;
- (c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.

(21) 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.

(22) CCOs shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.

(23) CCOs shall implement to the maximum extent feasible patientcentered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:

- (a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;
- (b) The applicant shall require its other health and services providers to communicate and coordinate care with patientcentered primary care homes in a timely manner using health information technology.

(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:

- (a) Describe its strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;
- (b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;
- (c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.

(25) CCOs are required to use alternative payment methodologies consistent with ORS 414.653. 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. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0120 and 409-025-0130.

(26) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;

(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.

(27) 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 MCE contract and external quality review with the Authority contracted External Quality Review Organization as outlined in CFR 42 §438.350, §438.358, and §438.364. The applicant shall provide assurances that:

(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;

(b) It submits APAC data in a timely manner pursuant to OAR 409-025-0130.

(28) CCOs shall be transparent in reporting progress and outcomes. Applicants 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.

(29) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:

(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;

(b) Whether the CCO uses a clinical advisory panel (CAP) or other means to ensure clinical best practices;

(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

(30) 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.

(31) 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.

(32) 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.

(33) CCOs shall provide covered Medicaid services other than Department of Human Services Medicaid-funded long-term care services to members who are dually eligible for Medicare and Medicaid.

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

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3020

RULE TITLE: Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation and Rule Precedence

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(2) In applying its policies, procedures, rules and interpretations, the Authority shall construe them as much as possible to be consistent. In the event that Authority policies, procedures, rules, and interpretations are inconsistent, the Authority shall apply the following order of precedence:

(a) For purposes of the provision of covered coordinated care services to Authority clients, including but not limited to authorizing and delivering service, or denials of authorization or services, the Authority, clients, enrolled providers, and the CCOs shall apply the following order of precedence:

(A) Consistent with ORS 413.071 and notwithstanding any other provision of state law, those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services (CMS) shall govern the administration of the medical assistance programs;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for CCOs, requirements applicable to providing coordinated care services to members are provided in this rule, the Division's General Rules, OAR 410-120-0000 through 410-120-1980 and the provider rules applicable to the category of health service;

(D) Generally for enrolled fee-for-service providers, requirements applicable to the provision of covered medical assistance to clients are provided in the Division's General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage set forth in OAR chapter 410 division 141 and the provider rules applicable to the category of health service;

(E) Any other applicable properly promulgated rules adopted by the Division, AMH and other offices or units within the Authority necessary to administer medical assistance programs, such as Electronic Data Transaction rules in OAR 943-120-0100 through 943-120-0200; and

(F) The basic framework for provider enrollment in OAR chapter 943 division 120 and chapter 410 division 120 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of medical assistance programs. For purposes of this rule, "more specific" means the requirements, laws, and rules applicable to the provider type and covered health services.

(b) For purposes of contract administration solely between the Authority and its CCOs, the contract terms and the requirements in section (2)(a) of this rule governing the provision of covered coordinated health services to clients.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3025

RULE TITLE: Coordinated Care Organization Governing Board Public Meeting and Transparency Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For purposes of the open meetings requirement in Section 2 of Enrolled 2018 HB 4018, 2018 Oregon Laws Chapter 49, "substantive decision" means a decision made by the governing board of a coordinated care organization (CCO) that relates to:

- (a) Spending of public funds;
- (b) The financial risk of the CCO;
- (c) Provider network development and capacity; or
- (d) The community advisory council, community health assessment, or community health improvement plan.

(2) Substantive decision does not require or include:

- (a) Disclosure of trade secrets as defined in ORS 192.345;
- (b) Confidential communications with a lawyer that are privileged under ORS 40.225;
- (c) Information of a personal nature as described in ORS 192.355;
- (d) Protected health information as defined in ORS 192.556;
- (e) Names of Oregon Health Plan consumer members of a community advisory council who request to remain anonymous;
- (f) Confidential human resource matters; or
- (g) Provider credentialing, sanctioning, or termination.

(3) The term "substantive decision" excludes immaterial technical decisions.

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

STATUTES/OTHER IMPLEMENTED: Oregon laws 2018 Chapter 49

REPEAL: 410-141-3030

RULE TITLE: Implementation and Transition

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

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

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

(2) Required subcontractor responsibilities are as follows:

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

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

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

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

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

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

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3040

RULE TITLE: Service Area Change (SAC) for Existing Coordinated Care Organizations (CCOs)

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

This rule shall be effective retroactively to December 27, 2015.

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

(a) "Applicant" means a coordinated care organization (CCO) as defined in ORS 414.625 with a CCO contract with the Authority that submits an application seeking recertification and 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) "Recertification" means the process outlined in this rule, allowing the CCO to submit an abbreviated application to apply as an existing CCO for a new CCO service area and that meets the requirements of ORS 414.625 and the standards set forth in this rule;

(e) "SAC packet" means the packet of application documents that the Authority provides to CCOs applying for a SAC;

(f) "Service Area Change" or "SAC" means a change in a CCO's service area as specified in the Authority's contract with the CCO;

(g) "Service area need" means when the Authority identifies a need, as defined in section (3) of this rule, for existing CCOs to apply to the Authority for a SAC to serve a service area.

(2) A CCO that desires to withdraw from all or a portion of its service area shall make every effort to provide the Authority with a form Letter of Intent to Exit the service area at least 150 calendar days prior to the intended date of withdrawal. The template for this form can be found on the CCO Contract Forms page at: www.oregon.gov/OHA/HSD/OHP/Pages/CCO-Contract-Forms.aspx. The Authority shall work with the CCO and any other impacted CCO for a workable exit transition.

(3) The Authority may determine a service area need exists, or is anticipated to exist, when a CCO would no longer be serving all or a portion of its service area.

(4) The Authority shall follow the process set forth in this rule when announcing a need for a SAC:

(a) Within thirty days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for the SAC. The announcement shall specify when the LOIA is due;

(b) Not later than fifteen calendar days from the date of the Authority's notification in section (4)(a) above, the Authority shall issue a second announcement of the Authority's identification of a need for a SAC and when LOIAs are due;

(c) To be considered for a SAC, interested CCOs shall submit their LOIAs by the deadline indicated in the Authority's notice of a need for a SAC. CCOs shall designate a sole point of contact in their LOIA for this process. The Authority will not accept a LOIA or any subsequent SAC application materials from a CCO that has not submitted a LOIA by the deadline indicated in the Authority's notice;

(d) The Authority shall send a letter of acknowledgement to the CCO within ten calendar days of receipt of the LOIA.

(5) Within thirty calendar days of the date specified by the Authority as the due date for submission of a LOIA, the CCO

shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC application packet. CCOs can locate a SAC packet on the CCO Contract Forms page at: www.oregon.gov/OHA/HSD/OHP/Pages/CCO-Contract-Forms.aspx. The completed SAC recertification application is the applicant's offer to enter into a contract for the period and service area specified in the SAC packet.

(6) CCOs applying for the service area change process outlined in this rule must meet the requirements set forth in ORS 414.625 and submit documentation as it applies to the new service areas indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3010 and 410-141-3015, shall be included in the acknowledgement letter sent by the Authority as described in section 4(d), which shall include, but is not limited to, information related to the following:

- (a) Delivery system network and provider capacity reports highlighting any providers operating in the new service area or existing contracted providers expanding their services into the new service area. This report would include providers of physical health, oral health, behavioral health, and non-emergent medical transportation. New relationships with dental care organizations (DCOs) and Non-Emergent Medical Transportation brokerages are to be included;
- (b) Updated financial reports;
- (c) Updated CCO governance organizational charts reflecting any changes due to new service area including CCO leadership and managerial staffing, changes to Community Advisory Committee members, Clinical Advisory Panels membership, and any other committee or governance structure change as a result of operating in the new service area;
- (d) Letters of community support from the community or communities in the new service area in which the CCO is applying to operate;
- (e) List of specific new zip codes the CCO intends to serve and the estimated enrollment for each zip code area;
- (f) Memorandums of understanding or letters of intent to enter into memorandums of understanding with local APD/AAA agencies, local mental health authority, local public health authority, and any other key stakeholders represented in the new service area;
- (g) Updated Community Health Improvement Plan (CHP) reflecting new service area goals, if applicable;
- (h) Updated Transformation Plan benchmarks or focus areas reflecting new service area goals, if applicable;
- (i) Information related to how services in the new service area will impact existing operations including updated policies and procedures as applicable;
- (j) Information related to identifying regional, cultural, socioeconomic, and racial disparities in health care that exist among the enrollees in the new service area and establishing community support for those areas of need; and,
- (k) Information related to coordination of care and transfer of new members, specifically high risk members or members with special health care needs.

(7) The Authority shall review SAC packets from all CCOs that have timely submitted a LOIA and SAC packet as required by this rule and that are considered responsive and completed as set forth in this rule.

(8) During its review of the SAC packets, the Authority may request additional information from a CCO. If additional information is requested, the CCO shall submit the additional information to the Authority within 30 days of the request.

(9) Within sixty calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information. Applicants are eligible for recertification based on criteria specified in section (6) of this rule, supporting documentation submitted by the applicant, and any additional information that the Authority obtains as part of the SAC process. 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) If two or more CCOs meet the requirements to expand into a service area based on criteria set forth in this rule, the Authority shall determine which CCO will be selected to serve the new service area utilizing the criteria set forth in OAR 410-141-3015(4).

(11) The Authority shall prepare a contract amendment for document review and signature to each CCO that receives recertification to expand into the new service area. The CCO shall have sixty calendar days to return an executed

contract amendment for the service area change.

(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3267.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.645, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 413.042

REPEAL: 410-141-3041

RULE TITLE: CCO Contract Renewal Notification Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) No later than 134 days prior to the end of a benefit period, the Authority shall provide each CCO with notice of the proposed changes to the terms and conditions of the contract for the next benefit period that the Authority submits to the Centers for Medicare and Medicaid Services for approval.

(2) If a CCO declines a contract renewal with the Authority, the CCO must notify the Authority of its intention not to enter into the contract renewal no later than 14 days after the Authority's notice of proposed changes as described in section (1).

(3) A CCO's notice to the Authority of intent not to enter into a contract renewal terminates the contract at the end of the benefit period unless:

(a) The Authority at its discretion requires the contract to remain in force into the next benefit period and be amended as proposed by the Authority until 90 days after the CCO has in accordance with criteria prescribed by the Authority:

(A) Notified each of its members and contracted providers of the termination of the contract;

(B) Provided to the Authority a plan to transition its members to other CCOs; and

(C) Provided to the Authority a plan for closing out its CCO business.

(b) The Authority may at its discretion waive compliance with the deadlines stated in sections (2) or (3) if the Authority determines such waiver to be consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651, 414.652

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3050

RULE TITLE: CCO Enrollment for Children Receiving Health Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

Pursuant to OAR 410-141-3060, 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 enroll the child in accordance with 410-141-0050.

(1) The Authority shall to the maximum extent possible ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority unless the Authority authorizes disenrollment from a CCO:

(a) Except as provided in OAR 410-141-3060 (Coordinated Care Enrollment Requirements), 410-141-3080 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO on the basis of third party resources (TPR) coverage;

(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 consider whether the Authority shall enroll the child in a CCO.

(2) When a child is transferred from one CCO to another CCO or from FFS or a PHP to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3160:

(a) CCOs shall work closely with the Authority to ensure continuous CCO enrollment for children;

(b) If the Authority determines that it should disenroll a child from a CCO, the CCO shall continue to provide health services until the Authority's established disenrollment date to provide for an adequate transition to the next CCO.

(3) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to the CCO's service area at the end of the temporary placement;

(b) A CAF child receiving behavioral rehabilitation services (BRS) is considered a temporary placement;

(c) Children in OYA custody enroll with the CCO serving the geographic area of placement. OYA representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary.

(4) If the Authority enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall pay for covered health services during that placement even if the location of the facility is outside the CCO's service area:

(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment;

(b) Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO unless the provisions in OAR chapter 410, division 141 apply;

(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.

(5) Except for OAR 410-141-3060 and 410-141-3080, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3060

RULE TITLE: Enrollment Requirements in an MCE

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(a) "Client" means an individual found eligible to receive OHP health services;

(b) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;

(c) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(d) "Renewal," means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) Pursuant to ORS 414.631, the following populations may not be enrolled into an MCE for any type of health care coverage including:

(a) Individuals who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients with Medicare receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).

(3) The following may not be enrolled in an MCE:

(a) A newly eligible OHP client who became eligible while admitted as an inpatient in a hospital is exempt from enrollment with a CCO for physical health services but not exempt from MCE enrollment oral health services with a DCO. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client;

(b) A client who is covered under a major medical insurance policy or other third-party resource (TPR) that covers the cost of services to be provided by an MCE as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO for oral health services even if they have a dental TPR.

(4) Individuals who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from mandatory enrollment into an MCE, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) A child in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area unless:

(a) Access to health care on a 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.

(6) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:

(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at

their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;

(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;

(c) A Medicare and full Medicaid dually eligible member may request to opt-out of enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment preserves continuity of care. In these cases, the member may not be disenrolled without review as deemed appropriate by the Authority that could include any of the following circumstances for individuals with conditions, treatments, or other specialized considerations requiring individualized case transition, including elements such as the following in the development of a prior-authorized treatment plan:

(i) Care management requirements based on the beneficiary's medical condition;

(ii) Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations;

(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services;

(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 410-141-3160 and 410-141-3170 are required regardless of the member's choices in Medicare and Medicaid enrollments.

(7) 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) In addition to the requirements in OAR 410-141-3080(3)(c)(A), a pregnant woman at any point prior to the end of the twenty-seventh week and sixth day of pregnancy who meets the qualifications in paragraphs A through E below may receive OHP benefits on a FFS basis for physical health only, until 60 days post estimated date of delivery. Women receiving services FFS for their physical health plan coverage shall continue to be enrolled in the appropriate MCE plan in their service area for oral health and behavioral health services. Sixty days after the estimated date of delivery, the member shall re-enroll in a plan as appropriate. Qualifying criteria are as follows:

(A) Member is pregnant;

(B) Member is in an established relationship with a licensed practitioner who is not a participating provider with the client's CCO;

(C) Member must make a request to change to FFS. This request can be made through the end of the twenty-seventh week and sixth day of pregnancy;

- (D) Member meets all relevant state and federal rules; and
- (E) If a woman becomes unable to meet the requirements, the exemption shall be withdrawn, and she shall be subject to CCO enrollment requirements as set forth in OAR 410-141-3060.
- (c) The following apply to clients and exemptions relating to organ transplants:
- (A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;
- (B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area.
- (d) Other just causes to preserve continuity of care include the following:
- (A) Enrollment poses a serious health risk; and
- (B) The Authority finds no reasonable alternatives.
- (8) Unless stated above, 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.
- (9) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.
- (10) 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 member does not select an MCE, the Authority shall auto-assign the member and the member's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:
- (a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or
- (b) The member shall be enrolled with a CCO for physical health and behavioral health services and with a DCO for oral health services; or
- (c) The member shall be enrolled with a CCO for behavioral health and oral health services and shall remain FFS for physical health services; or
- (d) The member shall be enrolled with a CCO for behavioral health services and with a DCO for oral health services and shall remain FFS for physical health services; or
- (e) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services and shall remain FFS for physical health services; or
- (f) The member shall be enrolled with a DCO for oral health services and remain FFS for physical health and behavioral health services; or
- (g) The member shall remain FFS for health care services if no MCE is available.
- (11) If a service area changes from mandatory enrollment to voluntary enrollment, 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 410-141-3080.
- (12) Members who are exempt from physical health services shall receive behavioral health services and oral health services through an MCE:
- (a) The member shall be enrolled with a CCO that offers behavioral health and oral health services; or
- (b) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services; or
- (c) The member shall be enrolled with a DCO for oral health services and shall remain FFS for behavioral health services if an MHO is not available; or
- (d) The member shall remain FFS for both behavioral health and oral health services if neither a DCO nor an MHO is available.
- (13) The following pertains to the effective date of the enrollment. If the 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.
- (14) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:

- (a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;
- (b) For individuals other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;
- (c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;
- (d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3061

RULE TITLE: Transition of Care Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) This rule applies to care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after the disenrollment of the member from another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or from Medicaid fee-for-service (FFS). Both instances shall be considered as the predecessor plan. This rule does not:

(a) Apply to a member who is disenrolled from Medicaid or who has a gap in coverage following disenrollment from the predecessor plan;

(b) Require the receiving CCO to provide care to a member other than as required by the member's enrollment in the CCO.

(2) Definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3000 Acronyms and Definitions and 410-200-0015 General Definitions:

(a) "Continued Access to Care" means the receiving CCO provides access to medically necessary covered services and care coordination without delay during a member's transition of care;

(b) "Prior Authorized Care" means covered services authorized by the predecessor plan. CCOs are responsible for providing continued access to care during a transition of care, consistent with applicable federal and state law, to members described in section (3). The receiving CCO must cover all prior authorized care to such members for the transition of care period defined in (5) and (6) until the CCO is able to develop an evidence-based, medically appropriate care plan;

(c) "Receiving CCO" means the CCO remains responsible for identifying persons in need of integration and care coordination as required in OAR 410-141-3160 and intensive care coordination services under OAR 410-141-3170 Intensive Care Coordination Services and the provision of both services as appropriate;

(d) "Transition of Care" means continued access to services during a member's transition from a predecessor plan to the receiving CCO.

(3) CCOs must implement and maintain a transition of care policy that at a minimum meets the requirements defined in this rule and 42 CFR 438.62(b). A receiving CCO must provide transition of care to, at minimum, the following members:

(a) Medically fragile children;

(b) Breast and Cervical Cancer Treatment program members;

(c) Members receiving CareAssist assistance due to HIV/AIDS;

(d) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and

(e) Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

(4) The receiving CCO:

(a) Is not responsible for payment of the following services:

(A) Health related services as defined in OAR 410-141-3150;

(B) Inpatient hospitalization or post hospital extended care, for which a predecessor CCO was responsible under its contract.

(b) Remains responsible for care coordination and discharge planning activities in conjunction with others as described in OAR 410-141-3160 and OAR 410-141-3170.

(5) The transition of care period is the greater of the following periods after the effective date of enrollment with the receiving CCO:

(a) Thirty days for physical and oral health and sixty days for behavioral health or until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan, whichever comes first;

(b) Ninety days for members who are dually eligible for Medicaid and Medicare.

(6) During the transition of care period, the receiving CCO shall ensure that any member identified in section (3) has continuing access to care as defined in (2)(a) previously authorized and is permitted to retain the member's previous provider, regardless of CCO provider participation except for the following:

(a) After the minimum or authorized prescribed course of treatment has been completed; or

(b) If the reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider;

(c) Notwithstanding section (6)(a) and (b), the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the service-specific continuity of care period situations below:

(A) Prenatal and postpartum care;

(B) Transplant services through the first-year post-transplant;

(C) Radiation or chemotherapy services for the current course of treatment; or

(D) Prescriptions with a defined minimum course of treatment that exceeds the continuity of care period.

(d) Where this section (6) allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less than Medicaid fee-for-service rates.

(7) A receiving CCO shall obtain written documentation as necessary for transition of care from the following:

(a) The Division's clinical services for members transferring from FFS;

(b) Other CCOs as needed; and

(c) Previous providers with member consent when necessary.

(8) During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization of ongoing covered services:

(a) CCOs shall not delay service authorization if written documentation of prior authorization is not available in a timely manner;

(b) In such instances, the CCO is required to approve claims for which it has received no written documentation during the transition of care time period, as if the services were prior authorized.

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

(a) Data shall be provided in a HIPAA compliant format to facilitate transitions of care;

(b) The minimum elements provided are:

(A) Current prior authorizations and pre-existing orders;

(B) Prior authorizations for any services rendered in the last 24 months;

(C) Current behavioral health services provided;

(D) List of all active prescriptions;

(E) Current ICD-10 diagnosis.

(10) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3225 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR §438.404 and OAR 410-141-3240.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-3066

RULE TITLE: CCO Enrollment Requirements for Temporary Out-of-Area Behavioral Health Treatment Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(a) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders;

(b) "Home CCO" means enrollment in a Coordinated Care Organization (CCO) in a given service area, based upon a client's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization;

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

(2) The Authority has determined that, to the maximum extent possible, all individuals shall be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. This rule implements and further describes how the Authority administers its authority under OAR 410-141-3060 and OAR 410-141-3080 for purposes of making enrollment decisions for adult and young adult individuals, 14 through and including 17 years of age, receiving temporary out-of-area behavioral health treatment services:

(a) For program placements in Child Welfare, Behavioral Rehabilitative Services, Oregon Youth Authority, and Psychiatric Residential Treatment Services, see OAR 410-141-3050 for program specific rules;

(b) For program placements in Secure Children's In-Patient (SCIP) and Secure Adolescent In-Patient (SAIP), CCOs shall work with the Authority in managing admissions and discharges;

(c) The member shall remain enrolled with the CCO for delivery of SCIP and SAIP services. The CCO shall bear care coordination responsibility for the entire length of stay, including admission, determination, and planning.

(3) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO on the same day the individual is admitted to the residential treatment services, the CCO shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO's service area. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(4) CCO assignment is based on the member's residence and referred to as Home CCO. Home CCO enrollment for temporary out-of-area placement shall:

(a) Meet Oregon residency requirements defined in OAR 410-200-0200;

(b) Be eligible for enrollment into a CCO as specified in OAR 410-141-3060;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to hospital, institutional, and residential placement. If the client has no enrollment history, new enrollment shall reflect most recent permanent residence prior to hospital, institutional, and residential placement; and

(d) Be consistent with OAR 410-141-3080 when the client exercises recipient choice, where the client is able to actively participate in their own recovery and direct their own care. If the client is unable to designate county of residence, as indicated in OAR 410-200-0200, the Authority shall designate the Home CCO as the geographic location of the client at the most recent residency and CCO enrollment prior to hospitalization.

(5) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:

(a) Upon State Hospital discharge, the Authority and the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement;

(b) If the client has no residency or enrollment history or no recent pre-hospitalization enrollment history, but the

client's permanent residency is indicated other than temporary placement location, the Authority shall enroll pursuant to section (3) (c) of this rule Home CCO enrollment;

(c) If the client has no residency or enrollment history prior to hospitalization, the Authority shall enroll in placement service area.

(6) For new and existing temporary residential placements, CCOs shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, dental, and transportation when within the scope of the CCO's contract, including when member's temporary placements are outside the CCO service area. CCO's shall coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, CCO's shall coordinate all care for accompanying dependent members.

(7) Enrollment shall follow the Home CCO enrollment policy outlined in this rule, except when:

(a) The Home CCO enrollment hinders access to care or puts the client at potential harm, or the Home CCO is unable to provide needed unique services, a change in enrollment may be requested for the member to a CCO serving the service area of the temporary out-of-area placement;

(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3080. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.

(8) Pursuant to OAR 410-141-3080, if the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO. If the individual was enrolled in a different CCO in error, the Authority shall disenroll the individual from the incorrect CCO and recoup the capitation payments, pursuant to OAR 410-120-1395. Re-enrollment to the correct CCO shall occur as specified in OAR 410-141-3060.

(9) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3080 shall apply. If the Authority determines that disenrollment should occur, the CCO shall continue to provide covered services until the disenrollment date established by the Authority, pursuant to 410-141-3160. This shall provide for an adequate transition to the next responsible coordinated care organization.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.610 - 414.685

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.610 - 414.685

REPEAL: 410-141-3070

RULE TITLE: Preferred Drug List Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

- (1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. MCEs shall pay for prescription drugs except:
 - (a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants) (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);
 - (b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (13), (14), and (15) of this rule;
 - (c) For drugs covered under Medicare Part D when the client is fully dual eligible.
- (2) MCEs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.
- (3) MCEs may use a restrictive drug list if it allows access to other drug products not on the drug list through prior authorization (PA).
- (4) MCEs shall publish up-to-date, accurate, and complete lists of all covered drugs on their preferred drug lists, including any tiering structures, that have been adopted and any restrictions on the way certain drugs may be obtained.
- (5) As specified in 45 CFR 156.122, the preferred drug list must:
 - (a) Exist in a manner easily accessible to members and potential members, state and federal government, and the public;
 - (b) Be accessible on the plan's public website in a machine-readable format through a clearly identifiable web link or tab without requiring an individual access account or policy number;
 - (c) Be made available in paper form if requested by a member; and
 - (d) If the issuer has more than one plan, the member shall be easily able to discern which of the preferred drug lists applies to which plan.
- (6) The preferred drug list shall:
 - (a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;
 - (b) Include at least one item in each therapeutic class of over-the-counter medications; and
 - (c) Be revised periodically to assure compliance with this requirement.
- (7) MCEs shall cover at least one form of contraception within each of the eighteen methods identified by the FDA. As set forth in OAR 410-141-3320, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating provider.
- (8) MCEs shall provide their participating providers and their pharmacy subcontractor with:
 - (a) Their drug list and information about how to make non-drug listed requests;
 - (b) Updates made to their drug list within 30 days of a change that may include but are not limited to:
 - (A) Addition of a new drug;
 - (B) Removal of a previously listed drug; and
 - (C) Generic substitution.
- (9) Prior authorization for prescription drug requests shall be addressed by the MCEs as described in OAR 410-141-3225.
- (10) MCEs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the prescriber certifies medical necessity for the drug such as:

- (a) The equivalent of the drug listed has been ineffective in treatment; or
 - (b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.
- (11) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.
- (12) MCEs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the list available at:
<https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e>
- (13) An MCE may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all the following information:
- (a) The drug name;
 - (b) The FDA approved indications that identify the drug may be used to treat a severe mental health condition; and
 - (c) The reason the Authority should consider this drug for carve out.
- (14) If an MCE requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.
- (15) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). An MCE may not reimburse providers for carved-out drugs.
- (16) MCEs shall submit quarterly utilization data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.
- (17) MCEs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. MCEs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.
- (18) MCEs shall utilize a pharmacy and therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, if all committee requirements for both committee types are met. A P&T committee must maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR 156.122(3)(i) and (ii). Meetings shall be held at least quarterly. MCEs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations.
- (19) The committee in its DUR capacity shall assure prescriptions are appropriate, medically appropriate, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined and described by 42 CFR 456, subpart K and Section 1902(o) of the Social Security Act [42 U.S.C. 1396a(o)].

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610–414.685