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PERMANENT ADMINISTRATIVE ORDER

FILED
12/13/2018 8:40 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 103-2018
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Medicare/Medicaid Dual Eligible Enrollment Changes

EFFECTIVE DATE: 01/01/2019

AGENCY APPROVED DATE: 11/30/2018

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AMEND: 410-141-3060

RULE TITLE: Enrollment Requirements in an MCE

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes improve rule readability and provide clarification in changes necessary to implement the Dual-Eligible Passive Enrollment Initiative consistent with Oregon's approved 1115 demonstration waiver.

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