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

FILING CAPTION: Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness

EFFECTIVE DATE: 01/01/2019

AGENCY APPROVED DATE: 11/30/2018

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RULES:
410-141-3015, 410-141-3160, 410-141-3180, 410-141-3220

AMEND: 410-141-3015

RULE TITLE: Criteria for Coordinated Care Organizations

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 changes ae needed for compliance with Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness. Rule changes needed to ensure compliance with the OPP are intended to: (1) Ensure access to Assertive Community Treatment (ACT); (2) Ensure mobile crisis response times and reporting occur within parameters set; (3) Ensure access to Peer Delivered Services; (4) Ensure warm handoffs to the community from Acute Care Psychiatric Facilities; (5) Ensure there is a management plan for individuals with three or more admissions in a six-month period of time admitted to Acute Care Psychiatric Facilities and Emergency Departments; (6) Ensure CCO involvement in discharges from the Oregon State Hospital and Secure Residential Treatment Facilities.

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 patientcentered primary care homes and individualized care:
(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;
(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate followup care when entering or leaving an acute care facility or long-term care setting 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: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3160

RULE TITLE: Integration and Care Coordination

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 changes ae needed for compliance with Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness. Rule changes needed to ensure compliance with the OPP are intended to: (1) Ensure access to Assertive Community Treatment (ACT); (2) Ensure mobile crisis response times and reporting occur within parameters set; (3) Ensure access to Peer Delivered Services; (4) Ensure warm handoffs to the community from Acute Care Psychiatric Facilities; (5) Ensure there is a management plan for individuals with three or more admissions in a six-month period of time admitted to Acute Care Psychiatric Facilities and Emergency Departments; (6) Ensure CCO involvement in discharges from the Oregon State Hospital and Secure Residential Treatment Facilities.

RULE TEXT:

(1) In order to achieve the objectives of providing MCE members integrated person-centered care and services, MCEs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment (CHA) and community health improvement plan (CHP).

(2) MCEs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.

(3) At a minimum, populations shall include members with special health needs, older adults, individuals who are blind, deaf, hard of hearing or with other disabilities, members who have complex medical needs, multiple chronic conditions, mental illness, or chemical dependency, or receive Medicaid-funded long-term care or long-term services and supports as defined in OAR 410-141-3000. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

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

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

(6) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document in the member's record and share the results of its health risk screening identifications appropriate for Intensive Care Coordination/Exceptional Needs Care Coordination (ICC/ENCC) services as defined in 410-141-3000:

(a) With participating medical providers serving the member;

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

(c) With members receiving Medicaid-funded long-term care or long-term services and supports and their case manager and their LTSS provider, if approved by the member; and

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

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

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

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

supportive care and services;
(b) Provided contact information for any ICC staff or formally designated person or entity with the primary responsibility for coordinating the services with the member;
(c) MCEs shall monitor subcontractors to ensure language and disability access are provided consistently across services and settings of care.
(8) For members with special health care needs determined through a health risk screening, MCEs shall have a process to allow enrollees direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.
(9) MCEs shall have processes to receive referrals for members receiving long-term care or long-term services and supports from the Department and referrals for intensive care coordination within 30 days, or as quickly as the member's health condition requires.
(10) MCEs shall produce a treatment or service plan for members with special health care needs, including members receiving LTC or LTSS that are determined through a health assessment to need a course of treatment or regular care monitoring:
(a) Such treatment plans shall be developed with any providers caring for the member, including any community-based support services and LTSS providers; and
(b) Include consultations with any specialist caring for the member and Department long-term care or long-term services and supports, providers, or case managers:
(c) MCEs shall share information as needed to prevent duplication of efforts in assessments, care planning, and care coordination as follows:
(A) With the Department Aging and People with Disabilities and the Office of Developmental Disability Services case managers for members with Medicaid long-term care or long-term services and supports;
(B) Skilled nursing facilities when applicable;
(C) With other MCEs serving members; and
(D) With Medicare Advantage Plans serving dual eligible members.
(d) MCEs shall use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving Department Medicaid-funded long-term care services and supports. Plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals to ensure engagement and satisfaction and ensure authorization of services reflects rules outlined in OAR 410-141-3225 MCE Service Authorization.
(11) MCEs shall coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:
(a) With the services the enrollee receives from any other MCE;
(b) With the services the enrollee receives in FFS Medicaid; and
(c) With the services the enrollee receives from community and social support providers.
(12) MCEs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.
(13) To the maximum extent feasible, CCOs shall develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs:
(a) PCPCHs shall become the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;
(b) MCEs shall develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology where available;
(c) MCEs shall engage other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.

(14) If an MCE implements other models of patient-centered primary health care in addition to the use of PCPCH, the MCE shall ensure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. The MCE shall:
(a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible MCE participating provider type;
(b) Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity;
(c) MCEs shall develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. MCEs shall ensure that all other services and supports are provided as close to the member's residence as possible:
(A) MCE members who are Indians (AI/AN) shall be permitted to select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE or may select an out-of-network IHCP from whom the enrollee is otherwise eligible to receive such primary care services;
(B) An out-of-network IHCP may refer an MCE member who is an Indian to an in-network provider without prior authorization or referral from a participating provider.
(d) MCEs shall maintain contracts with providers of residential chemical dependency treatment services and notify the Authority within 30 days of executing new contracts;
(e) MCEs shall maintain a contractual relationship with any dental care organizations necessary to provide adequate access to oral services in the area where members reside;
(f) MCEs shall assess the needs of its membership and make available supported employment and assertive community treatment services available when members are referred and eligible. Appropriate ACT providers are those that meet the requirements in OAR 309-019-0225 through 309-019-0255. Appropriate supported employment services providers are those that meet the requirements in OAR 309-019-0270 through 309-019-0320. When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to make supported employment and assertive community treatment services available;
(g) MCEs shall report the number of individuals with SPMI who receive supported employment services at a frequency to be determined by OHA.
(15) MCEs shall have adequate, timely, and appropriate access to hospital and specialty services. MCEs shall establish hospital and specialty service agreements that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for after-hospital follow up appointments.
(16) MCEs shall demonstrate how hospitals and specialty services shall be accountable to achieve successful transitions of care. MCEs shall ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the state hospital.
(17) When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service or PHP to an MCE, the MCE shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an MCE participating provider.
(18) The MCE shall implement systems to assure and monitor transitions in care so that members receive

comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the process for members accessing care coordination.
(19) For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), the MCE shall notify the appropriate Department office and begin appropriate discharge planning. The MCE shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled in the MCE during the hospitalization preceding the nursing facility placement:
(a) MCEs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
(b) For members who are discharged to Medicare Skilled Care, the MCE shall notify the appropriate Department office when the MCE learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care;
(c) MCEs shall coordinate transitions to Department Medicaid-funded long-term care services and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care (LTC) settings.
(20) MCEs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs:
(a) The MCE shall establish procedures for coordinating member health services and how it will work with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of MCE services with long-term care services and crisis management services;
(b) MCEs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members receiving Medicaid-funded long-term care or long-term services and supports;
(c) MCEs shall establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget.
(21) A CCO may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. (See OAR 410-141-3000 for the definition of an IMD.) The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):
(a) For members aged 21-64;
(b) As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
(c) The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
(A) The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
(B) The CCO must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
(C) The approved in lieu of services are authorized and identified in the CCO contract and may be offered to members at the CCO's option.
(22) If the member is living in a Department Medicaid funded long-term care (LTC) nursing facility or community-based care facility or other residential facility, the MCE shall communicate with the member and the Department Medicaid funded long-term care provider or facility about integrated and coordinated care services.

(23) An MCE shall demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities).
(24) The MCE shall communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. MCEs shall document all monitoring and corrective action activities.
(25) MCEs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. MCEs shall coordinate the care of members that enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the state hospital and are transitioning from the Oregon State Hospital.
(26) MCEs shall coordinate a member's care even when services or placements are outside the MCE service area. MCE assignment is based on the case member's residence and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department, or health services placements for services including residential placements may be located out of the service area; however, the MCE shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the MCE enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.
(27) Except as provided in OAR 410-141-3050, MCEs shall coordinate patient care, including care required by temporary residential placement outside the MCE service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon:
(a) MCE enrollment shall be maintained in the county of origin with the expectation of the MCE to coordinate care with the out of area placement and local providers;
(b) The MCE shall coordinate the discharge planning when the member returns to the county of origin.
(28) MCEs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the MCE's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The MCE shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3225 MCE Service Authorization.
(29) MCEs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional, as defined in OAR 410-120-0000, 410-141-3225, or 410-141-3240, and shall ensure a notice of action/adverse benefit determination notice is issued for an adverse benefit determination or service authorization denial, including request for referrals that are denied.
(30) MCEs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.
(31) MCEs shall accept FFS authorized services, medical, and pharmacy prior authorizations; ongoing services where a FFS prior authorization is not required, and services authorized by the Division's Medical Management Review Committee. This shall occur within 90 days or until the MCE can establish a relationship with the member and develop an evidence-based, medically appropriate coordinated care plan, whichever is later. The exception is when customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610–414.685

AMEND: 410-141-3180

RULE TITLE: Record Keeping and Use of Health Information Technology

NOTICE FILED DATE: 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 changes ae needed for compliance with Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness. Rule changes needed to ensure compliance with the OPP are intended to: (1) Ensure access to Assertive Community Treatment (ACT); (2) Ensure mobile crisis response times and reporting occur within parameters set; (3) Ensure access to Peer Delivered Services; (4) Ensure warm handoffs to the community from Acute Care Psychiatric Facilities; (5) Ensure there is a management plan for individuals with three or more admissions in a six-month period of time admitted to Acute Care Psychiatric Facilities and Emergency Departments; (6) Ensure CCO involvement in discharges from the Oregon State Hospital and Secure Residential Treatment Facilities.

RULE TEXT:

(1) MCEs shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC §1320-d et seq., the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. MCEs shall communicate these policies and procedures to subcontractors. MCEs shall regularly monitor its subcontractors' compliance and take any corrective action necessary. MCEs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(2) A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices. MCE's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member requests copies of their records.

(3) Notwithstanding ORS 179.505, an MCE, its provider network, and programs administered by the Department's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services, and reimbursement in order to improve the safety and quality of care, lower the cost of care, and improve the health and well-being of the members.

(4) An MCE and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and behavioral health diagnoses within the MCE for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Re-disclosure of individually identifiable information outside of the MCE and the MCE's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 and 414.655 remains subject to any applicable federal or state privacy requirements including the Authority's rules established in OAR 943-014-0000 through 0070 for matters that involve privacy and confidentiality and privacy of members protected information.

(5) The MCE must document its methods and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports:

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

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

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

family in care management and treatment planning;
(d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources; for example, the use of certified or qualified health care interpreters, as defined in ORS 413.550, community health workers, and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;
(e) Members have access to advocates; for example, qualified peer wellness specialists, peer-delivered support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
(f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
(6) MCEs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, MCEs shall:
(a) Identify EHR adoption rates. Rates may be divided by provider type and geographic region;
(b) Develop and implement strategies to increase adoption rates of certified EHRs;
(c) Encourage EHR adoption.
(7) MCEs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and oral health information with any other provider in that MCE.
(8) MCEs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
(9) MCEs shall initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:
(a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness, and cost-efficiency of treatment);
(b) Quality and utilization reporting to facilitate quality improvement within the MCE as well as to report the data on quality of care that allows the Authority to monitor the MCEs performance;
(c) Patient engagement through HIT, using existing tools such as e-mail; and
(d) Other appropriate uses for HIT (e.g., telehealth, mobile devices).
(10) MCEs shall maintain health information systems that collect, analyze, integrate, and report data and are able to provide information on areas including but not limited to the following:
(a) Names and phone numbers of the member's primary care provider or clinic, primary dentist, and behavioral health provider;
(b) Copies of Client Process Monitoring System (CPMS) enrollment forms;
(c) Copies of long-term psychiatric care determination request forms;
(d) Evidence that the member has been informed of rights and responsibilities;
(e) Complaint and appeal records;
(f) Disenrollment requests for cause and the supporting documentation;
(g) Coordinated care services provided to enrollees through an encounter data system; and
(h) Based on written policies and procedures, the record keeping system developed and maintained by MCEs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practices and facilitate an adequate system to allow the MCE to ensure that data received from providers is accurate and complete by:
(A) Verifying the accuracy and timeliness of reported data;
(B) Screening the data for completeness, logic, and consistency; and
(C) Collecting service information in standardized formats to the extent feasible and appropriate.

(11) MCEs and their provider network shall cooperate with the Authority, the Department of Justice Medicaid Fraud Control Unit (MFCU), and CMS or other authorized state or federal reviewers for purposes of audits, inspection, and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services are authorized and provided, referrals are made, and outcomes of coordinated care and referrals are sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.
(12) Across the MCE's provider network, all clinical records shall be retained for a minimum of ten years after the date of services for which claims are made. Contractors shall maintain any other records, books, documents, papers, plans, records of shipments, and payments and writings, whether in paper, electronic, or other form that are pertinent in a manner that clearly documents contractor's performance. All clinical records, financial records, other records, books, documents, papers, plans, records of shipments, and payments and writings of the contractor whether in paper, electronic, or other form are collectively referred to as "Records." If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the ten-year period, the clinical records must be retained until all issues arising out of the action are resolved.
(13) MCEs shall allow access to the agencies listed in section (12) of all audit records and its subcontractors and participating provider's records to allow the listed agencies to perform examinations and audits and make excerpts and transcripts and to evaluate the quality, appropriateness, and timeliness of services.
(14) MCEs shall allow access to the entities listed in section (12) at any time to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. MCEs subject to an audit under this section shall retain records for ten years from the final date of the contract period or from the date of completion of the most recent state audit, whichever is later. MCEs shall retain and keep accessible all records for a minimum of ten years. County agencies participating in the Medicaid program are subject to whichever record retention requirement is longer between this rule and OAR chapter 166, division 150 County and Special District Retention Schedule.
(15) MCEs must maintain yearly logs of all appeals and grievances for ten years following requirements specified in OAR 410-141-3255.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3220

RULE TITLE: Accessibility

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 changes ae needed for compliance with Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness. Rule changes needed to ensure compliance with the OPP are intended to: (1) Ensure access to Assertive Community Treatment (ACT); (2) Ensure mobile crisis response times and reporting occur within parameters set; (3) Ensure access to Peer Delivered Services; (4) Ensure warm handoffs to the community from Acute Care Psychiatric Facilities; (5) Ensure there is a management plan for individuals with three or more admissions in a six-month period of time admitted to Acute Care Psychiatric Facilities and Emergency Departments; (6) Ensure CCO involvement in discharges from the Oregon State Hospital and Secure Residential Treatment Facilities.

RULE TEXT:

(1) Consistent with the community health assessment and health improvement plan, MCEs must assure that members have access to high quality care. The MCE shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The MCE shall develop and implement the assessment and plan over time that meets access-to-care standards and allows for appropriate choice for members. The goal shall be that services and supports shall be geographically as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

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

(3) In developing its access standards, the MCE shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered approach. The MCE provider network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.

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

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

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

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

(6) MCEs shall make the services it provides including: Primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K as accessible to members for timeliness, amount, duration, and scope as those services are to other members within the same service area. If the MCE is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. MCEs shall have a monitoring system that shall demonstrate to the Authority that the MCE has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) MCEs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention, and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues or when a member over utilizes services;
(b) MCEs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members;
(c) If ten or more CCO enrolled members in a CCO region have been referred, are eligible and are appropriate for ACT, and are on a waitlist to receive ACT that has lasted for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or
(B) By adding additional ACT teams;
(C) When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to increase capacity and add additional teams.
(7) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, behavioral health issues, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO is responsible for oral care), behavioral health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.
(8) MCEs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred as within the following timeframes:
(a) Emergency care, immediately or referred to an emergency department depending on the member's condition;
(b) Urgent care, within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-0140;
(c) Well care, within four weeks or within the community standard;
(d) Emergency oral care (when oral care is provided by the MCE or DCO), seen or treated within 24-hours;
(e) Urgent oral care (when oral care is provided by the MCE or DCO), within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and
(f) Routine oral care (when oral care is provided by the MCE or DCO), seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason that makes access longer than 12 weeks appropriate;
(g) Non-Urgent behavioral health treatment, seen for an intake assessment within two weeks from date of request.
(9) MCEs shall develop policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or there is no telephone:
(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in MCE administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;
(b) MCEs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint, make a diagnosis, respond to member's questions and concerns, and communicate instructions to the member;
(c) MCEs shall ensure the provision of coordinated care services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;
(d) MCEs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for

services to be provided by non-participating referral providers when necessary;

(e) MCEs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685