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

FILING CAPTION: New Administrative Rules on Governing Coordinated Care Organizations (CCOs) 3630-3835

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RULES:
410-141-3630, 410-141-3635, 410-141-3640, 410-141-3645, 410-141-3650, 410-141-3655, 410-141-3700, 410-141-3705, 410-141-3710, 410-141-3715, 410-141-3720, 410-141-3725, 410-141-3730, 410-141-3735, 410-141-3740, 410-141-3800, 410-141-3805, 410-141-3810, 410-141-3815, 410-141-3820, 410-141-3825, 410-141-3830, 410-141-3835

ADOPT: 410-141-3630

RULE TITLE: MCE Assessment: Determining Assessment Liability on Failure to File

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:
(1) In the case of a failure by the MCE to file a report or to maintain necessary and adequate records, the Authority shall determine the MCE assessment liability according to the best of its information and belief.
(2) Best of its information and belief means the Authority shall use evidence available to the Authority at the time of the determination on which a reasonable person would rely on to determine the assessment.
(3) The Authority's determination of assessment liability shall be the basis for the assessment due in any notice of proposed action.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3635

RULE TITLE: MCE Assessment: Financial Penalty for Failure to File a Report or Failure to Pay Assessment When Due

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) An MCE that fails to file a report or pay an MCE assessment in full when due is subject to a penalty of up to $500 per day of delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(2) The total amount of penalty imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which the penalty is being imposed.

(3) In determining the amount of the penalty, the Authority shall consider evidence, such as:

(a) The MCE's history of prior late payments and prior penalties;

(b) The MCE's actions to come into compliance;

(c) The occurrence of unforeseeable circumstances against which it would have been unreasonable for the MCE to take precautions and which the MCE cannot avoid even by using its best efforts. Such circumstances include, but are not limited to, a natural disaster (e.g., earthquakes, floods, tornadoes), fires, an act of war (e.g., hostilities, invasion, terrorism, civil disorder), or other circumstances not within the reasonable control of the MCE;

(d) In the case of a deficiency due to an error when the MCE files a timely original return and pays the assessment identified in the return, the nature and extent of the error, evidence of prior errors, and the MCE's explanation of the circumstances related to the error.

(4) The Authority shall collect any penalties imposed under this section and deposit the funds in the Health System Fund.

(5) Penalties paid under this section are in addition to the MCE assessment.

(6) If the Authority determines that an MCE is subject to a penalty under this section, the Authority shall issue a notice of proposed action as described in OAR 410-141-3640.

(7) If an MCE requests a contested case hearing, the Director of the Authority, at the Director's sole discretion, may reduce the amount of penalty assessed.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3640

RULE TITLE: MCE Assessment: Notice of Proposed Action

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Prior to issuing a notice of proposed action, the Authority shall notify the MCE of a potential deficiency or failure to report that could give rise to the imposition of a penalty. The Authority shall issue a 30-day notification letter within 30 calendar days of the report or payment due date. The MCE shall have 30 calendar days from the date of the notice to respond. The Authority may consider the response, if any, and any amended report under OAR 410-141-3615 in its notice of proposed action. In all cases that the Authority has determined that an MCE has an MCE assessment deficiency or failure to report, the Authority shall issue a notice of proposed action. The Authority may not issue a notice of proposed action if the issue is resolved satisfactorily within 59 days from the date of mailing the 30-day notification letter.

(2) The Authority shall issue a notice of proposed action within 60 calendar days from the date of mailing the 30-day notification letter.

(3) Contents of the notice of proposed action must include:

(a) The applicable calendar quarter;

(b) The basis for determining the corrected amount of assessment for the quarter;

(c) The corrected assessment due for the quarter as determined by the Authority;

(d) The amount of assessment paid for the quarter by the MCE;

(e) The resulting deficiency, which is the difference between the amount received by the Authority for the calendar quarter and the corrected amount due as determined by the Authority;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of delinquency;

(h) Date upon which the penalty began to accrue;

(i) Date the penalty stopped accruing or circumstances under which the penalty will stop accruing;

(j) The total penalty accrued up to the date of the notice;

(k) Instructions for responding to the notice; and

(L) A statement of the MCE's right to a hearing.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3645

RULE TITLE: MCE Assessment: Hearing Process

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Any MCE that receives a notice of proposed action may request a contested case hearing pursuant to ORS 183.411 through 183.500.

(2) The MCE may request a hearing by submitting a written request within 20 days of the date of the notice of proposed action.

(3) Prior to the hearing, the MCE shall meet with the Authority for an informal conference:

(a) The informal conference may be used to negotiate a written settlement agreement;

(b) If the settlement agreement includes a reduction or waiver of penalties, the agreement must be approved and signed by the Director of the Authority.

(4) Except as provided in section (5) of this rule, if the case proceeds to a hearing, the administrative law judge shall issue a proposed order with respect to the notice of proposed action. The Authority shall issue a final order.

(5) Nothing in this section shall preclude the Authority and the MCE from agreeing to informal disposition of the contested case at any time.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3650

RULE TITLE: MCE Assessment: Final Order of Payment

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

The Authority shall issue a final order of payment for deficiencies or penalties when:

(1) The MCE did not make a timely request for a hearing;

(2) Any part of the deficiency or penalty was upheld after a hearing;

(3) Upon agreement of the MCE and the Authority.

STATUTORY/OTHER AUTHORITY: ORS 414.025, ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3655

RULE TITLE: Assessment: Remedies Available after Final Order of Payment

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

Any amounts due and owing under the final order of payment and any interest thereon may be recovered by Oregon as a debt to the state, using any available legal and equitable remedies which include but are not limited to:

(1) Collection activities including but not limited to deducting the amount of the final deficiency or penalty from any sum then or later owed to the MCE by the Authority;

(2) Every payment obligation shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the final order of payment and continuing until the payment obligation, including interest, has been discharged.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3700

RULE TITLE: CCO Application and Contracting Procedures

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The Authority shall establish an application process for entities seeking contracts as CCOs, in conformity with this OAR 410-141-3700 and OAR 410-141-3705. The following definitions apply with respect to that application process:

(a) "Applicant" means the entity submitting an application to be a CCO, or to enter into or amend a contract for coordinated care services;

(b) "Application" means an applicant's written response to a Request for Applications;

(c) "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.

(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 include, at a minimum, the elements required under OAR 410-141-3705, and 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 issue CCO contracts only to applicants that meet the criteria in OAR 410-141-3705, 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;
(b) The Authority shall notify each applicant that applies for CCO status if it meets the criteria for being a CCO;
(c) 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.
(d) 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;
(e) 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.
(f) 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. The “award date” refers to the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts. 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, OEBB, 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

ADOPT: 410-141-3705

RULE TITLE: Criteria for CCOs

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) In administering the procurement process described in OAR 410-141-3700, the Authority shall require applicants to describe their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System, including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall develop an RFA that includes, at a minimum, the elements described in this rule:

(a) This rule lists legal requirements for CCOs, followed by corresponding application requirements that CCO applicants shall be required to address in the RFA;

(b) The Authority shall interpret the qualifications and expectations for CCO contracting within the context of the laws establishing health system transformation, as well as the Oregon Health Policy Board's adopted reports and policies;

(c) The Authority's evaluation of CCO applications shall account for the developmental nature of the CCO system:

(A) The Authority recognizes that CCOs and partner organizations need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System;

(B) An applicant who does not yet satisfy an RFA criterion must, at a minimum, have plans in place to meet the criterion. Unless otherwise specified in law or in the RFA, the Authority may use discretion in assessing whether the applicant is likely to make sufficient progress in implementing those plans to merit selection as a CCO candidate. Depending on the applicant's level of readiness, the Authority may consider invoking its authority under OAR 410-141-3700(4)(f) to deem an applicant "potentially eligible;"

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

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

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

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

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

(c) Operating within a fixed global budget;

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

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

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

(3) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. 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 Medicaid-funded long-term care, services, and supports.
(4) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. 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.
(5) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:
(a) Since community health assessments evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before operating as a CCO;
(b) The applicant shall describe how it develops its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community needs that builds on community resources and skills and emphasizes innovation.
(6) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3730.
(7) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:
(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;
(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.
(8) CCOs shall provide integrated, 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.
(9) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to certified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall describe:
(a) Planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, peer-delivered services specialists, personal health navigators, and qualified community health workers where appropriate;
(b) Planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.
(10) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:
(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;
(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.

(11) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:
(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and 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 oral health care when the CCO includes a dental care organization, and facilitate access to community social and support services including Medicaid-funded LTCSS, mental health crisis services, and culturally and linguistically appropriate services;
(i) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.
(12) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.
(13) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using 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.
(14) 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.
(15) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, and Traditional Health Workers (THW). THWs include:
(a) Peer wellness specialists;
(b) Peer-support specialists;

(c) Personal health navigators;
(d) Family support specialist;
(e) Youth support specialist;
(f) Doulas; and
(g) Community health workers navigators.
(16) The applicant shall describe its planned policies for informing members about access to all types of THWs identified in OAR 410-180-0305.
(17) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:
(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;
(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;
(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long-term psychiatric care settings.
(18) CCOs shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with serious and persistent mental illness covered under the state's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:
(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;
(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(19) CCOs shall participate in the learning collaborative described in ORS 413.259. Applicants shall confirm their intent to participate.
(20) CCOs shall implement to the maximum extent feasible 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.
(21) CCOs' health care services shall be culturally and linguistically appropriate and focus on achieving health equity and eliminating health disparities. The applicant shall describe its strategy for:
(a) Ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;
(b) Engaging in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;
(c) Collecting and maintaining race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards established by the Authority.
(22) CCOs are required to use alternative payment methodologies consistent with ORS 414.653. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0125 and 409-025-0130. The applicant shall describe its plan to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.

(23) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:
(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 Roadmap for meeting transformation expectations;
(b) Its plan to support increased rates of electronic health record adoption among contracted providers, and to ensure that providers have access to health information exchange for care coordination;
(c) Its plan to use HIT to make use of hospital event notifications and to administer value-based payment initiatives.
(24) CCOs shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the APAC data reporting system, and follow expectations for participation in annual TQS reporting to the Authority as detailed in the contract and external quality review with the Authority contracted External Quality Review Organization as outlined in 42 CFR §§ 438.350, 438.358, and 438.364. The applicant shall provide 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, or it will submit, APAC data in a timely manner pursuant to OAR 409-025-0130.
(25) CCOs shall be transparent in reporting progress and outcomes. The applicant shall:
(a) Describe how it assures transparency in governance;
(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that are transparent and publicly reported and available on the Internet.
(26) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:
(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;
(b) Whether the CCO uses a clinical advisory panel (CAP) or other means to ensure clinical best practices;
(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.
(27) CCOs shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:
(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Division of Financial Regulation on behalf of the Authority to confirm financial solvency and assess fiscal soundness;
(b) The applicant shall provide information relating to assets and financial and risk management capabilities.
(28) CCOs may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.
(29) CCOs shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3710

RULE TITLE: Contract Termination and Close-Out Requirements

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) This rule applies to any termination of an MCE contract, including but not limited to non-renewal under OAR 410-141-3725, expiration of the contract at the end of its term, or termination during the term of the contract initiated by either party. Consistent with OAR 410-141-3725, MCEs shall abide by all requirements in this rule regardless of whether termination notice is provided by the Authority or the MCE.

(2) The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery and a contemporaneous copy emailed to the other party's contract administrator.

(3) The notice of termination shall specify the circumstances giving rise to termination and the date on which such termination shall become effective.

(4) After receipt of an MCE's notification of intent not to renew or notice of termination, the Authority shall issue written notice to the MCE specifying:

(a) The effective date of termination;

(b) The MCE's operational and reporting requirements; and

(c) Timelines for submission of deliverables.

(5) Upon notification of termination or non-renewal, an MCE shall submit to the Authority a transition plan detailing how it fulfills its continuing obligations for the duration of the contract. The transition plan shall include:

(a) How each of the MCE's members and contracted providers are notified of the termination of the contract;

(b) A plan to transition its members to other MCEs; and

(c) A plan for closing out its MCE business, including but not limited to the operational and reporting requirements and timelines for submission of deliverables, as specified by the Authority, and the requirements specified in this rule.

(6) Transition plans are subject to approval by the Authority:

(a) The MCE must revise the transition plan as necessary to obtain approval by the Authority;

(b) Failure to submit a transition plan and obtain written approval of the termination plan by the Authority may result in the Authority's withholding of 20 percent of the MCE's monthly capitation payment until the Authority has approved the transition plan;

(c) If the Authority's approval of the transition plan occurs less than 90 days before the effective date of termination, then the Authority may require the MCE to extend the contract to a later effective date of termination, including as necessary the MCE's acceptance of amendments to the contract generally applicable to MCE contracts through the extended effective date.

(7) The MCE shall designate an individual as the contract transition coordinator.

(8) The contract transition coordinator shall be the Authority's contact for ensuring the MCE's completion of the MCE's contractual obligations, performance, operations, and member transitions including the transition plan.

(9) MCEs must submit reports to the Authority every 30 calendar days detailing the MCE's progress in executing its transition plan. In the event of the MCE's substantial failure to execute timely its transition plan, the Authority may withhold 20 percent of any payments due to the MCE from the Authority until such failure is corrected.

(10) MCEs shall submit a final report to the Authority describing how it fulfilled all transition and close-out activities described in the transition plan. The final report is subject to the Authority approval before issuance of any final payment.

(11) MCEs shall continue to perform all financial, management, and administrative services obligations identified in contract throughout the closeout period, including at minimum:
(a) Restricted reserves and insurance coverage for a period of 18 months following the notice of termination, or until the state provides the MCE with written release agreeing that all continuing obligations are fulfilled, whichever is earlier;
(b) Maintaining adequate staffing to perform all required functions as specified in contract;
(c) Supplying all information necessary to the Authority or its designee upon request for reimbursement of any outstanding claims at the time of termination;
(d) Assisting the Authority to ensure an orderly transition of member services after notice of termination consistent with the Authority's Transition of Care Policy; and
(e) To make available all signed provider agreements or subcontracts to the Authority upon request.
(12) The MCE must arrange for the orderly transfer of all OHP members assigned to the MCE to coverage under any new arrangement authorized by the Authority, including any actions required by the Authority to complete the transition of members and the termination of the MCE contract. These actions include:
(a) Forwarding of all medical or financial records related to the contractually obligated activities;
(b) High needs care coordination;
(c) Facilitation and scheduling of medically necessary appointments for care and services;
(d) Identification of chronically ill high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.
(13) If a change of providers may be harmful to the member, the MCE must continue to provide services until that treatment is concluded or appropriate transfer of care is arranged.
(14) The MCE shall make available and require its providers and subcontractors to make available to the Authority copies of medical, behavioral, oral and managed long-term services and supports records, patient files, and any other pertinent information necessary for efficient care management of enrollees, as determined by the Director of the Authority:
(a) Records shall be in a usable form and shall be provided at no expense to the Authority, using a file format and dates for transfer specified by the Authority;
(b) Under no circumstances shall a Medicaid member be billed for this service;
(c) Information that shall be required includes:
(A) Numbers and status of grievances in process;
(B) Numbers and status of hospital authorizations in process, listed by hospital;
(C) Daily hospital logs;
(D) Prior authorizations approved, pending, or denied;
(E) Program exceptions approved;
(F) Medical cost ratio data;
(G) Information on outstanding payments for medical care rendered to members;
(H) All encounter data required under the terminated agreement;
(I) Identification of members whose treatment or treatment plans require continuity of care consideration;
(J) Any other information or records deemed necessary by the Authority to facilitate the transition of care.
(15) Following expiration of the contract and the completion of closeout period obligations, the MCE shall:
(a) Maintain claims processing functions as necessary for a minimum of 18 months after the date of termination. If additional claims are outstanding, the MCE shall maintain the claims processing system as long as necessary to complete final adjudication of all claims;
(b) Remain liable and retain financial responsibility for all claims with dates of service prior to the date of termination;
(c) Maintain financial responsibility for patients who are hospitalized prior to the termination date through the date of discharge or for patients receiving post hospital extended care benefits after termination to the extent the MCE is responsible under the contract;
(d) Maintain financial responsibility for services rendered prior to the termination date, for which payment is denied by

the MCE and subsequently approved upon appeal by the provider; and
(e) Assist the Authority with grievances and appeals for dates of service prior to the termination date.
(16) Runout activities shall consist of the processing, payment, and reconciliations necessary regarding all enrollees, claims for payment from providers, appeals by both providers and members, and financial reporting deemed necessary by the Authority, including:
(a) Monthly claims aging report including IBNR amounts;
(b) Quarterly financial statements and annual audited financial statements in conformity with the specification in the contract up to the date specified by the Authority;
(c) Certified encounter reporting until all services rendered prior to contract expiration or termination have reached adjudicated status and the Authority data validation of the information is complete;
(d) Arranging for the retention, preservation, and availability of all records, including those records related to member grievance and appeals, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement, and those records covered under HIPAA as required by contract and state and federal law;
(e) Details of any existing third-party liability (TPL) or personal injury lien (PIL) cases and making any necessary arrangements to transfer the cases to the Authority's TPL and PIL units; and
(f) Final reports that identify all expenditures for any period in which the MCE continued to pay claims for services provided during the contract period.
(17) The Authority may require status reports or updates to the data reporting requirements in section (16) upon request.
(18) MCEs shall submit to the Authority a written request for release certifying that all obligations have been satisfied. The Authority shall provide an official written release upon satisfaction of activities associated with the contract expiration or termination plan. The request must be signed, expressly under penalty of False Claims Act liability, by the president and the chief financial officer of the MCE and must attest that, except as expressly described in a writing attached to the attestation:
(a) All payments are received by the MCE under the contract, and all the MCE's liabilities under the contract are extinguished;
(b) All reports, reconciliations, member matters, and provider matters are resolved and finalized; and
(c) The MCE complied with all contractual and legal requirements, including completion of the activities described in the transition plan.
(19) To the extent that the request for release under section (18) attaches any exception, the request for release must include a plan describing how each exception is resolved. Any payments due under the terms of the contract for services between the Authority and the MCE, including the distribution of restricted reserve funds or any withheld capitation amount, may be withheld until the Authority receives all written and properly executed documents from the MCE. The MCE is subject to all obligations under the contract, associated rules, and the transition plan until a final written release is issued by the Director of the Authority. Such release:
(a) Shall apply only to the extent of the MCE's responsibilities under the MCE contract, associated rules, and the transition plan;
(b) Shall apply only to the extent the MCE's submissions to the Authority are true, complete, and accurate;
(c) Shall apply only between the Authority and the MCE;
(d) May not bind third parties;
(e) May not preclude the Authority's assertion of indemnity, contribution, or other obligations based on third-party claims;
(f) May not preclude the Authority's assertion of false claims liability, Medicaid fraud, common-law fraud, or other claims, false statements, or fraud; and
(g) May not affect any post-termination obligations of the MCE under the contract for preservation of records or for auditors' access.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3715

RULE TITLE: CCO Governance; Public Meetings and Transparency

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

(2) Consumer Representative means a person serving on a CAC who is currently or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian, or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(3) Each CCO's governing body must include:

(a) At least one member representing persons that share in the financial risk of the organization;

(b) A representative of a dental care organization selected by the coordinated care organization;

(c) The major components of the health care delivery system;

(d) At least two health care providers in active practice, including:

(A) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

(B) A mental health or chemical dependency treatment provider.

(e) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(f) At least two members of the CAC:

(A) At least one of the CAC representatives on the CCO's governing body must be a current CAC Consumer Representative;

(B) Any CAC member serving on a CCO governing board must disclose any conflicts of interest;

(C) CAC members of the governing body shall have full voting rights.

(4) 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.

(5) 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.

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625

STATUTES/OTHER IMPLEMENTED: Oregon Laws 2018 Chapter 49

ADOPT: 410-141-3720

RULE TITLE: Service Area Change for Existing CCOs

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(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 a contract amendment for a new service area. The CCO is described for purposes of this rule as the applicant upon its submission of the CCO Letter of Intent to Apply;

(b) "Document Review" means the review conducted by the Authority, occurring at the point after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant's ability to serve Medicaid beneficiaries in the requested service areas;

(c) "Letter of intent to apply (LOIA)" means a letter from a CCO to the Authority stating the CCO's intent to submit a SAC packet in response to a service area need. A LOIA may be binding or non-binding, as specified in the Authority's announcement of the service area need;

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

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

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

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

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

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

(a) Within 30 days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for the SAC. The announcement shall specify when the LOIA is due;

(b) Not later than 15 calendar days from the date of the Authority's notification in section (4)(a) 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 10 calendar days of receipt of the LOIA.

(5) Within 30 calendar days of the date specified by the Authority as the due date for submission of a LOIA, the CCO shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC application packet. CCOs can locate a SAC packet on the CCO Contract Forms page.

(6) CCOs applying for the service area change process outlined in this rule must meet the requirements set forth in ORS 414.625 and submit documentation as it applies to the new service areas indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3700 and 410-141-3705, shall be included in the acknowledgement letter sent by the Authority as described in section 4(d), 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 60 calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information. To be eligible for recertification in the new service area, the applicant must meet standards established by the Authority, this rule, and be in compliance with the contract between the CCO and the Authority.
(10) The Authority shall determine which CCO(s) will be selected to serve the new service area under the procedures and criteria set forth in OAR 410-141-3700(4) and 3705.
(11) The Authority shall prepare a contract amendment for document review and signature to each CCO that receives approval to expand into the new service area. The CCO shall have 60 calendar days to return an executed contract amendment for the service area change.
(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3550.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625, 414.645

STATUTES/OTHER IMPLEMENTED: ORS 413.042

ADOPT: 410-141-3725

RULE TITLE: CCO Contract Renewal Notification

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

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.

(4) A CCO that declines to renew its contract shall comply with the termination and close-out requirements in OAR 410-141-3710, except as otherwise provided in this rule.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3730

RULE TITLE: Community Health Assessment and Community Health Improvement Plans

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) CCOs shall comply with the requirements in ORS 414.627 and 414.629, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.

(2) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.

(3) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-E partners, as defined in OAR 410-141-3735;

(d) Local mental health authorities and community mental health programs;

(e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

(g) Indian Health Care Providers;

(h) Traditional Health Workers;

(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions; and

(k) Representatives from populations who are experiencing health and health care disparities.

(4) The CHA must include or identify and analyse at a minimum, all of the following:

(a) The demographics of all of the Communities with Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, gender, and sexual orientation;

(b) The health status and issues of all the Communities within Contractor's Service Area;

(c) The health disparities among all of the Communities within Contractor's Service Area;

(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;

(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);

(f) Assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:

(A) Access to primary prevention resources;

(B) Disproportionate, unmet, health-related needs;

(C) Description of assets within the Community that can be built on to improve the Community's health;

(D) Systems of seamless continuum of care; and
(E) Systems or programs of collaborative governance of community benefit.
(g) Means to promote the health and early intervention in the treatment of children and adolescents within Contractor's Service Area, and whether they are sufficient and effective;
(h) Areas for improvement; and
(i) The persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.
(5) CCOs and their CACs must develop baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, neighborhood and environment, or other factors. This data will be used to identify and prioritize strategies to reduce health disparities in the development of their CHPs.
(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).
(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP. The CCOs' CACs are responsible for adopting CHPs.
(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:
(a) County and city government representatives;
(b) Federally recognized tribes (if not already collaborating on a shared CHA);
(c) SDOH-E partners, as defined in OAR 410-141-3735;
(d) Local mental health authorities and community mental health programs;
(e) Physical, behavioral, and oral health care providers;
(f) Federally Qualified Health Centers;
(g) Indian Health Care Providers;
(h) Traditional Health Workers;
(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;
(j) Culturally specific organizations, including Regional Health Equity Coalitions; and
(k) Representatives from populations who are experiencing health and health care disparities.
(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.
(a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:
(A) Closing the gap on disproportionate, unmet, health-related needs;
(B) Creating access to primary prevention;
(C) Building a system of seamless continuum of care;
(D) Building on current Community resources and improving Community capacity to improve health or address SDOH-E, or both; and
(E) Engaging the Community in the implementation of the CHP.
(b) The CHP strategies should be based on research and may include, without limitation:
(A) Developing a or supporting Health Policy that supports the CHP goals and objectives;
(B) Implementing or supporting community health or SDOH-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

(C) Developing public and private resources and capacities;
(D) Designing and building a system of Integrated service delivery;
(E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.
(c) The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies;
(d) The CHP must also address, with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the needs of adolescents and children in a CCO's Service Area and must address:
(A) Findings based on research, including adverse childhood experiences;
(B) The adequacy of existing school-based health center (SBHC) networks and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community;
(C) The integration of all services provided to meet the needs of children, adolescents, and families; and
(D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.
(10) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and improving health equity. Progress reports will be submitted in the manner and form proscribed by OHA.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3735

RULE TITLE: Social Determinants of Health and Equity; Health Equity

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) This rule defines health disparities and the social determinants of health and equity (SDOH-E), establishes requirements for the Supporting Health for All through Reinvestment Initiative (SHARE Initiative), establishes the role of the Community Advisory Councils in supporting SDOH-E, establishes requirements for collecting data on race, ethnicity, and primary language, and establishes requirements for developing health equity infrastructure within a Coordinated Care Organization (CCO). This rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.

(2) The following definitions apply for purposes of this rule:

(a) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the indicators used to track progress toward achieving health equity.

(b) "Social Determinants of Health and Equity" (SDOH-E):

(A) SDOH-E encompasses three terms:

(i) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities;

(ii) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities;

(iii) Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.

(B) SDOH-E initiatives may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:

(i) Community-level interventions that directly address social determinants of health or social determinants of equity;

(ii) Interventions to address individual health-related social needs.

(c) "SDOH-E Partner" is a single organization, local government, one or more of the Federally-recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area.

(3) The following requirements are specific to the Supporting Health for All through Reinvestment Initiative (SHARE Initiative):

(a) For each calendar year starting on or after January 1, 2021, CCOs shall dedicate a portion of their previous calendar year's net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018) and as set forth in the contract;

(b) CCOs shall select SDOH-E spending priorities that fall into at least one of four domains of SDOH-E: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health, and are consistent with:

(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other

stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs; and
(B) Any SDOH-E priority areas identified by the Authority.
(c) A portion of SHARE Initiative dollars must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract, a Memorandum of Understanding, or other form of agreement including a grant agreement, with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO.
(d) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.
(4) Community Advisory Councils (CAC):
(a) CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on SDOH-E, including the SHARE Initiative, and health-related services community benefit initiatives, as defined in OAR 410-141-3845. CCOs shall have a conflict of interest policy that applies to its CAC members and accounts for financial interests related to potential SDOH-E spending;
(b) CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues. These reports will be posted publicly with appropriate redactions.
(5) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.
(6) Health Equity Infrastructure:
(a) The term "Health equity infrastructure" refers to the adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality language access; workforce diversity; ADA compliance and accessibility of CCO and provider network; ACA 1557 compliance; CCO and provider network organizational training and development; implementation of the CLAS Standards; non-discrimination policies;
(b) The "Health Equity Plan" is part of the "Health Equity Infrastructure;"
(c) CCOs shall develop and implement the "Health Equity Plan" to embed health equity as a value and business practice into organizational policies, procedures, and processes; meet state and federal laws and contractual obligations regarding accessibility and culturally and linguistically responsive health care and services; inform using an equity framework in all policy, operational, and budget decisions; provide a structure to ensure oversight and management of programs and services with the goal to advance health equity and provide culturally and linguistically appropriate services. The health equity plan shall include the following:
(A) Narrative of the health equity plan development process, including description of meaningful community engagement;
(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics;
(C) Organizational and Provider Network Cultural Responsiveness and Implicit Bias training plan:
(i) CCO shall incorporate Cultural Responsiveness and implicit bias continuing education and training into its existing organization-wide training plan and programs;
(ii) CCO shall align cultural responsiveness and implicit bias trainings with the "Cultural Competence Continuing Education" criteria developed by the Authority's Cultural Competence Continuing Education Advisory Committee referenced in OAR 943-090-0020;
(iii) CCO shall adopt the definition of Cultural Competence set forth in OAR 943-090-0010;
(iv) CCO shall provide and require all its employees, including directors, executives, and CAC members to participate in all such trainings;
(v) CCO's shall require all of the CCO's Provider Network to comply with Cultural Competency Continuing Education requirements set forth in ORS 676.850.
(d) The health equity plan and the language access self-assessment report are required to be submitted under OAR 410-

141-3515 and shall be submitted every year to the Authority for review and approval;
(e) CCOs shall designate a Single Point of Accountability. The single point of accountability can also be called the Health Equity Administrator:
(A) The Single Point of Accountability ("Health Equity Administrator") shall be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network and CCO service area;
(B) The Single Point of Accountability ("Health Equity Administrator") shall have budgetary decision- making authority and health equity expertise;
(C) The Single Point of Accountability ("Health Equity Administrator") shall be a high-level employee (e.g., director level or above) and can have more than one area of responsibility and job title;
(D) The CCO shall inform and describe to the authority any changes related to the "Health Equity Administrator" role or scope using the Health Equity Plan;
(E) The Single Point of Accountability ("Health Equity Administrator") shall have the authority to communicate directly with CCO executives and governing board.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3740

RULE TITLE: Traditional Health Workers

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The Authority requires that all CCO members based on their health needs must have access to certified traditional health workers (THWs) who are part of the member's care team in clinical and community-based settings to ensure members have improved access to appropriate services. The THWs, as a part of the member's care team, must participate in processes affecting the member's care and service needs. THW is defined in OAR 410-180-0305.

(2) CCOs shall develop and implement a plan for integrating and utilizing THWs, in accordance with this rule and the CCO contract:

(a) THW integration and utilization plans shall include:

(A) Information on THW access and usage for CCO members;

(B) Benchmarks and measurement of baseline data for integration and utilization of THWs;

(C) Evaluations of the CCO's progress in reaching those benchmarks.

(b) THW integration and utilization plans shall be submitted to OHA as required under the contract.

(3) CCOs shall establish, based on OHA's and the Traditional Health Worker Commission guidelines, a THW payment grid that includes alternative and sustainable payment strategies. Each CCO shall provide its THW Payment Grid to OHA. OHA will then post each CCOs Payment Grid to make them publicly available.

(4) CCOs shall designate a THW liaison, who shall serve as the central point of contact for THW integration.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3800

RULE TITLE: CCO Enrollment for Children Receiving Health Services

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Pursuant to OAR 410-141-3805, the Authority or Oregon Youth Authority (OYA) shall select CCOs for a child receiving services in an area where a CCO is available. If a CCO is not available in an area, the Authority shall, to the extent feasible, enroll the child in an MHO in accordance with the procedures described in this rule; in such an event, the MHO is subject to the requirements described in this rule for CCOs.

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

(a) Except as provided in OAR 410-141-3805 (Coordinated Care Enrollment Requirements), 410-141-3810 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO or DCO on the basis of third-party resources (TPR) coverage consistent with OAR 410-141-3805;

(b) The Authority shall review decisions to use fee-for-service (FFS) open card for a child if the child's circumstances change and, at the time of redetermination, shall consider whether the Authority shall enroll the child in a CCO.

(3) When a child is transferred from one CCO to another CCO or from FFS to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3860:

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

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

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

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

(b) Children receiving children, adult, and family services from the Department who are eligible to be enrolled with the CCO serving the geographic area of placement: Department representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary;

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

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

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

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

(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage

with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.
(6) Except for OAR 410-141-3805 and 410-141-3810, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3805

RULE TITLE: Mandatory MCE Enrollment Exceptions

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

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

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

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

(2) CCO enrollment is mandatory in all areas served by a CCO. A client eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.

(3) MCE enrollment is mandatory in service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:

(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or

(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.

(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.

(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.

(6) Members who are exempt from physical health services shall receive behavioral health services and oral health 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.
(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:
(a) On or before Wednesday, the date of enrollment shall be the following Monday; or
(b) After Wednesday, the date of enrollment shall be one week from the following Monday.
(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:
(a) A newborn's services shall begin on the date of birth if 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.
(9) Pursuant to ORS 414.631, the following populations may not be enrolled into an MCE for any type of health care coverage:
(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 another Medicaid;
(c) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).
(10) In addition, the following enrollment rules apply:
(a) A newly eligible OHP client who became eligible while admitted as an inpatient in a hospital, or while receiving post-hospital extended care (PHEC), 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, or until the member completes PHEC or the PHEC benefit is exhausted;
(b) A client may not be enrolled in an MCE if the client 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 410-141-3800. A client shall, however, be enrolled with a DCO for oral health services even if they have a dental TPR.
(11) 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.
(12) 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 an FFS basis is not available; or
(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.
(13) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:
(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information

on the benefits for clients in aligning Medicare and Medicaid;
(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;
(c) A Full Medicare and Medicaid full dually eligible members 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 an FFS basis is not available; or
(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;
(i) The development of a prior-authorized treatment plan;
(ii) Care management requirements based on the beneficiary's medical condition;
(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and
(iv) Need for individual case conferences to ensure a "warm hand-off."
(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:
(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;
(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;
(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.
(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;
(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.
(14) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;
(b) The following apply to clients and exemptions relating to organ transplants:
(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;
(B) Newly eligible clients with existing transplants are not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care.
(15) MCE enrollment standards:
(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:
(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;
(B) Closed enrollment as a sanction for MCE misconduct.
(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;
(c) MCEs may confirm the enrollment status of a client by one of the following:

(A) The individual's name appears on the monthly or weekly enrollment list produced by the Authority;
(B) The individual presents a valid medical care identification that shows he or she is enrolled with the MCE;
(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the MCE;
(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the MCE.
(d) MCEs shall have open enrollment for 30 continuous calendar days during each 12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.
(16) If the Authority permits an MCE to assign its contract to another MCE, members shall be automatically enrolled in the MCE that has assumed the contract:
(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the MCE that has assumed the contract;
(b) If the MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.
(17) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area such that the MCE cannot meet the access to care requirements set forth in OAR 410-141-3515 and which necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:
(a) An MCE may provide less than the required 90-calendar-day notice to the Authority upon approval by the Authority when the MCE must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the MCE and refuses to provide the required 90-calendar-day notice;
(b) The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority shall instead notify members of a change in participating providers or MCEs. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3810

RULE TITLE: Disenrollment from MCEs

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Member-initiated requests for disenrollment.

(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule.

(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:

(A) Without cause:

(i) Members may request to change their MCE enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle.

(ii) Members may request to change their MCE enrollment within 90 calendar days of the initial MCE enrollment. If approved, the change would occur during the next weekly enrollment cycle.

(iii) Members may request to change their MCE enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month.

(iv) Members may request to change their MCE enrollment at their OHP eligibility renewal. If approved, the change would occur at the end of the month.

(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. If a request for disenrollment is approved under this section, the change would occur at the end of the month.

(B) With cause, at any time as follows:

(i) The member moves out of the MCE service area; or

(ii) Due to moral or religious objections the CCO does not cover the service the member seeks.

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

(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to fee-for-service at any time subject to the provisions set forth in OAR 410-1413805(13)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition.

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include but are not limited to:

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

(ii) The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member

for a provider of a treatment, service, or supply.
(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary CCO exemption.
(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the member's administrative hearing rights; and
(E) If 30 calendar days pass without a decision from the Authority on a member's disenrollment request, the request becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).
(c) A member may request a temporary enrollment exception during pregnancy as follows:
(A) A temporary enrollment request will be granted if a member is at any point in the third trimester of pregnancy and:
(i) The member is newly determined eligible for OHP; or
(ii) The member is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or
(iii) The member is enrolled with a new CCO MCE that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider.
(B) The enrollment exemption shall remain in place until 60 calendar days postdate of either the delivery of the member's child or the pregnancy otherwise ends, at which time the member shall be enrolled in the appropriate CCO in their service area. Where there is a choice among multiple CCOs in the member's service area they may choose an open plan; however, if the member does not express a preference to OHP, OHP will auto assign on a next weekly basis.
(d) Upon approval of a member's disenrollment from a CCO, the Member shall join another CCO unless:
(A) The member resides in a service area where enrollment is voluntary; or
(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805; or
(C) The member meets disenrollment criteria stated in this rule; or
(D) There is not another CCO available and open to new enrollment in the service area.
(2) MCE-initiated disenrollment requests.
(a) MCEs may request disenrollment for any of the reasons set forth below in this subsection (a). Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified in this subsection (a) below. After review of all necessary documentation submitted with an MCE's request, the Authority will grant such requests, except the Authority may deny requests based on the reason set forth in subparagraph (G) below.
(A) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization and the post-hospital extended care (PHEC) benefit. If the member is enrolled after the first calendar day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services, unless the member is a newborn child born to an OHP eligible mother enrolled with a CCO;
(B) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The CCO shall receive an emailed tracking number following the online report. The CCO may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO effective at the end of the month the TPL is reported. In some situations, the Authority may approve retroactive disenrollment;
(C) If a member has been residing outside the MCE's service area for more than three months unless previously arranged with the MCE. The MCE shall provide written documentation that the member has been residing outside its service area for more than three months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR will notify the MCE of the

approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;
(D) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;
(E) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution; or
(F) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the MCE.
(G) The member had End Stage Renal Disease at the time of enrollment in the MCE.
(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.
(a) MCEs have the right to request the Authority disenroll members when they commit fraudulent or illegal acts related to participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts.
(b) The MCE shall report any illegal acts to law enforcement authorities and, if appropriate, to the DHS Fraud Investigations Unit.
(c) When requesting disenrollment based on a member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, including any verification of reports submitted to law enforcement and, if applicable, the DHS Fraud Investigations Unit.
(d) Based on the evidence presented, the CCO AR will review the disenrollment request and all submitted evidence with Authority staff. The review process will be documented and a recommendation for disenrollment will be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.
(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.
(a) Subject to applicable disability discrimination laws and this subsection (4), the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule.
(b) For purposes of this rule, a "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the MCE shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or the best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; 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.
(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:
(A) Physical, intellectual, developmental, or mental disability; or
(B) An adverse change in the member's health; or
(C) Under or over-utilization of services; or
(D) Filing a grievance or exercising any appeal or contested case hearing rights; or

(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or
(F) Uncooperative or disruptive behavior resulting from the member's special needs.
(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member. The provider shall document the written notification to the MCE in the member's medical record.
(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:
(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider. The MCE shall document the education, training, and the resources or services furnished to the reporting provider.
(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:
(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;
(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and
(iii) Inform the member that their continued behavior may result in disenrollment from the MCE.
(C) In the event the interventions undertaken in accordance with Subsections (e)(B) of this rule do not ameliorate the member's uncooperative or disruptive behavior, the MCE shall Contact the member's care team, or develop a member focused care team if one does not already exist, to support the member in remediating their behavior. If needed, and with the consent of the member, the care team shall involve other appropriate individuals working with the member in the resolution within the laws governing confidentiality. The MCE shall facilitate cross functional care conferences that include the member, member focused care team, and other individuals chosen by the member with appropriate releases documented.
(D) In the event the member's uncooperative or disruptive behavior continues after undertaking the efforts identified in subsections (e)(C) of this rule, the MCE shall convene an interdisciplinary team that includes a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior, their behavioral history, and previous efforts undertaken to manage the member's behavior, including those developed through the members care team and care conferences, in order to determine whether the member may be able to remediate their uncooperative or disruptive behavior through other reasonable clinical or social interventions.
(f) All efforts undertaken in connection with this section (4) of the rule, including, without limitation, all interventions, written and oral communications, training and education provided to the member and the member's provider(s), as well as those persons who participated in any and all interventions, care teams, assessments and the like, shall be documented in the member's MCE case file and as applicable, the provider shall document all efforts undertaken in the member's medical record.
(g) If, after undertaking all efforts identified in subsection (e) of this rule, the member's disruptive or uncooperative behavior cannot be managed sufficiently in order for a provider to provide the services the member requires, the MCE may submit to its CCO AR on MCE letterhead a written request for disenrollment that complies with all of the following:
(A) Sets forth the reasons for the request for disenrollment, details the attempts at intervention and accommodations that were made, why those interventions and accommodations were not effective, and includes all written documentation required under subsection (f) of section (4) of this rule.
(B) Identifies, and provides documentation in support of the identification of, any special health care needs or disability the disruptive or uncooperative member may have and describes:

(i) The relationship the uncooperative or disruptive behavior may have, if any, to the member's special health care needs or disability, which must be substantiated by a provider with the appropriate credentials and expertise in the member's special health care needs or disability; and
(ii) Why the MCE has concluded the member's disruptive or uncooperative behavior is not a consequence of the member's special health care needs or disability.
(C) States whether the member's uncooperative or disruptive behavior poses a direct threat to the health or safety of others.
(D) Identifies the documentation that supports the MCE's rationale for concluding that the member's continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either the member who has engaged in the uncooperative or disruptive behavior or the MCE's other members.
(E) Provide written documentation of CMS' approval for disenrollment of the member when the member is also enrolled in the CCO's Medicare Advantage plan.
(F) Furnish all other information and documentation requested by the MCE's CCO AR.
(h) If a Primary Care Provider (PCP) terminates the provider/patient relationship during the period of time the CCO is undertaking the efforts described in this section (4), the CCO shall, prior to submitting a request for disenrollment, attempt to locate another participating PCP who will accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new PCP to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be consistent with the CCO's OHP policies, the CCO or PCP's policies for commercial members, and applicable disability discrimination laws.
(5) MCE Disenrollment Requests: Credible Threats of Violence.
(a) MCEs have the right to request an exception to the MCE initiated disenrollment requirements outlined in section (4) of this rule when a member has committed an act of, or made a credible threat of, physical violence directed at a health care provider, the provider's staff, other patients, or the MCE staff, so that it seriously impairs the MCE's ability to furnish services to either this particular member or other members.
(b) For purposes of this rule, a credible threat means that there is a significant risk that the member may cause grievous physical injury (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures.
(c) MCEs shall require their providers to notify both the MCE and law enforcement immediately when a member has acted violently or makes a credible threat of physical violence.
(A) The notification may be made to the MCE by telephone provided that such notice is followed by written notice to the MCE.
(B) Notice under this subsection (c) shall describe the circumstances surrounding the act or credible threat of violence and the actions taken by the provider as a result.
(C) MCEs shall require their providers to document the incident in the member's medical record and the MCE shall document the provider's notice in the member's case file.
(d) The MCE shall notify the member's care team of the act or credible threat of violence. The MCE shall involve the member's care team and, within the laws governing confidentiality, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior.
(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence.
(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes set forth in section (4) of this rule prior to making any request for disenrollment.
(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (d) of this section (5), by following the process set forth in section

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

(C) Information regarding the member's right to file a grievance and their administrative hearing rights; and
(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in OHA's record of the request and provided to the MCE for distribution the member's care team.
(f) The date of disenrollment shall be effective ten calendar days after the date of the member's disenrollment notice, unless:
(A) The member files a grievance or otherwise requests a hearing, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon such decisions; or
(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE will be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.
(7) Enrollment for Authority Approved Disenrollment.
(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or
(b) When circumstances permit, when there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or
(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR will place an enrollment exemption for the appropriate MCE CCO-A, CCO-B, CCO-E, and CCO-G plans and place the member on Open Card for a twelve month period, after which the CCO AR will reevaluate enrollment options for the member.
(8) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the MCE, all disenrollments are effective the end of the month the Authority approves the disenrollment.
(a) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority.
(b) If the member dies, the last date of enrollment shall be the date of the member's death.
(9) Transfers of 500 or more members.
(a) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one MCE to another MCE if:
(A) The member's provider has contracted with the receiving MCE and the provider has stopped accepting patients from the MCE from which the member is being transferred, or has terminated providing services to members who are enrolled with the MCE from which the member is being transferred;
(B) Members are offered the choice of remaining enrolled in the transferring MCE; and
(C) The member and all family (case) members shall be transferred to the provider's new MCE.
(b) The transfer shall become effective the date on which the provider's contract with their current MCE terminates or otherwise expires, or on another date approved by the Authority.
(c) Members shall not be transferred under this section (9) unless the following conditions have been satisfied:
(A) The Authority has evaluated the receiving MCE and determined that the receiving MCE meets criteria established by the Authority as stated in OAR 410-141-3705 including, but not limited to, ensuring that the MCE maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and
(B) The Authority has provided notice of a transfer to members affected by the transfer at least 90 calendar days before the scheduled date of the transfer.

STATUTORY/OTHER AUTHORITY: ORS 413.032, 414.615, 414.625, 414.635, 414.651, 42 CFR 438.56, 42 CFR 455.13, 42 CFR 438.420

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3815

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

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) 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 410-141-3805 and OAR 410-141-3810 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 410-141-3800 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.

(2) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO or FFS on the same day the individual is admitted to the residential treatment services, the CCO or FFS 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. Upon discharge, FFS members will, upon the next weekly enrollment period, enroll with the CCO that is contracted for their residential service area.

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

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

(b) Comply with the CCO enrollment rules specified in OAR 410-141-3805;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to temporary 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 410-141-3810 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.

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

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

(b) Beginning in Contract year 2022 (or later if specified by the Authority), if the client is enrolled in a CCO at the time of the acute care admission to the State Hospital when a bed becomes available, 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 CCO's responsibility shall be in accordance with a risk sharing agreement to be entered into between the CCO and the State Hospital, in a form required by the Authority. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(5) 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, oral, 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.
(6) 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; or
(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3810. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.
(7) Pursuant to OAR 410-141-3810, 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 410-141-3805.
(8) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3810 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 410-141-3860. This shall provide for an adequate transition to the next responsible coordinated care organization.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.610 - 414.685

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 414.610 - 414.685

ADOPT: 410-141-3820

RULE TITLE: Covered Services

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) General standard. The OHP Benefit Package includes treatments and health services which pair together with a condition on the same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified in any relevant Statements of Intent and Guideline Notes of the Prioritized List of Health Services. The Benefit Package also covers the additional services described in this rule.

(a) As used in OAR 410-141-3820 and 410-141-3825, the word "health services" has the meaning given in ORS 414.025(13);

(b) Services are covered with respect to an individual member only when the services are medically or orally necessary and appropriate as defined in 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ORS 743A.012;

(c) Benefit Package coverage of prescription drugs is discussed in OAR 410-141-3855;

(d) The Benefit Package is subject to the exclusions and limitations described in OAR 410-141-3825.

(2) MCE service offerings:

(a) MCEs shall offer their members, at a minimum:

(A) The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the MCE's mandatory scope of services; and

(B) Any additional services required in OAR chapter 410, or in the MCE contract.

(b) CCOs shall coordinate physical health, behavioral health and oral health care benefits;

(c) With respect to members who are dually eligible for Medicare and Medicaid, MCEs shall provide:

(A) OHP Benefit Package services except for Medicaid-funded long-term care, services, and supports; and

(B) Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan.

(3) Diagnostic services. Diagnostic services that are medically or orally appropriate and medically or orally necessary to diagnose the member's presenting condition (signs and symptoms) or guide management of a member's condition, regardless of whether the condition appears above or below the funded line on the Prioritized List of Health Services. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines on the Prioritized List of Health Services.

(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services. Preventive Services are included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, as specified in related guideline notes. 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.

(6) Ancillary services. Ancillary services are covered subject to the service limitations of the OHP program rules when:

(a) The services are medically or orally necessary and appropriate in order to provide a funded service; or

(b) The provision of ancillary services will enable the member to retain or attain the capability for independence or self-care;

(c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines on the Prioritized List of Health Services.

(7) SUD services. The provision of SUD services shall comply with OAR 410-141-3545.
(8) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k.
(9) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in 410-130-0245.
(10) Coverage of services for unfunded conditions based on effect on funded comorbid conditions:
(a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:
(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and
(B) The member 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.
(b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (10);
(c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis;
(d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:
(A) Treating health care provider opinion;
(B) Medical research; and
(C) Current peer review.
(11) Ensuring that all coverage options are considered:
(a) When a provider receives a denial for a non-covered service for any member, especially a member with a disability or with a co-morbid condition, the provider shall determine whether there may be a medically appropriate covered service to address the member's condition or clinical situation, before declining to provide the non-covered service. The provider's determination shall include consideration of whether a service for an unfunded condition may improve a funded comorbid condition under subsection (8);
(b) If a member seeks, or is recommended, a non-covered service, providers shall ensure that the member is informed of:
(A) Clinically appropriate treatment that may exist, whether covered or not;
(B) Community resources that may be willing to provide the relevant non-covered service;
(C) If appropriate, future health indicators that would warrant a repeat evaluation visit.
(c) Before an MCE denies coverage for an unfunded service for any member, especially a member with a disability or with a co-morbid condition, the MCE shall determine whether the member has a funded condition or condition/treatment pair that would entitle the member to coverage under the program.
(12) Assistance to providers. The Authority shall maintain a telephone information line for the purpose of assisting practitioners in determining coverage under the OHP Benefit Package. 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 Authority shall make a retrospective determination under this section, provided the Authority is notified of the emergency situation during the next business day. If the Authority denies a requested service, the Authority 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.
(13) Ad hoc coverage determinations.

(a) If a member seeks a service pertaining to a funded condition and a funded or unfunded treatment that does not pair with the same condition on the HERC Prioritized List of Health Services, and coverage is not otherwise available pursuant to this rule, or excluded by any applicable statute, and the member requests an appeal from their MCE or a hearing from fee for service, the MCE or Division must make an ad hoc determination on an individual basis as to whether the treatment may be medically or orally appropriate and necessary for the member;
(b) If the member requests a hearing the Division determines whether the HERC has considered the funded condition/treatment pair for inclusion on the Prioritized List within the last five years. If the HERC has not considered the pair for inclusion within the last five years, the Division shall make an ad hoc coverage determination in consultation with the HERC:
(c) Ad hoc determination of individual cases is based on the Division's assessment of whether the treatment is medically appropriate and necessary for the patient and meets the other relevant rules and program standards. Ad hoc determinations shall include consideration of the patient's medical history, the treating provider's recommendation, available medical research and professional guidelines. Ad hoc determinations may be informed by consultations with specialists with relevant expertise on the condition or treatment in question;
(A) If the Division determines that the requested treatment is not appropriate and necessary, the Division will uphold the denial. The member may then proceed to hearing;
(B) If the Division determines that the requested treatment is appropriate and necessary for the member's condition, the Division will overturn the denial and approve the coverage by exception. This determination will not need to proceed to hearing.
(d) If the Division hearing overturns a MCE's coverage determination, the MCE may invoke the dispute resolution procedures in OAR 410-141-3550.
(14) General anesthesia for oral procedures. General anesthesia for oral procedures that are medically and orally necessary and 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

ADOPT: 410-141-3825

RULE TITLE: Excluded Services and Limitations

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The following services are excluded from the Oregon Health Plan Benefit Package, except as otherwise provided in OAR 410-141-3820:

(a) Any service identified for exclusion in OAR 410-120-1200 or 410-120-1210;

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

(c) Any service that is not a funded service, even if it is provided for a condition that appears in the funded region of the list, or if the service in question is a funded service when provided for an unfunded diagnosis on the prioritized list;

(d) Services that, when provided, are funded services on the Prioritized List of Health Services, but which are otherwise excluded from the OHP Benefit Package for the client in question;

(e) Diagnostic services not reasonably necessary to establish a diagnosis or guide management or treatment decisions, regardless of whether the condition or treatment in question is a funded service;

(f) Services requested by OHP clients in an emergency care setting that do not satisfy the coverage rules in OAR 410-141-3820;

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

(h) Services other than inpatient care provided to an OHP client 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 410-141-3810;

(i) Services received while the client is outside the MCE's service area, except for services that were:

(A) Ordered or referred by the client's primary care provider; or

(B) Urgent or emergency services; or

(C) Otherwise covered pursuant to rule or the MCE contract;

(D) This exclusion does not apply if the client was outside the MCE's service area because of circumstances beyond the client's control. Factors to be considered include but are not limited to death of a family member outside of the MCE's service area. If the client successfully establishes this fact, including during the grievance and appeal process, then this exclusion does not apply.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are medically appropriate and necessary to provide reasonable diagnosis and treatment; enable the OHP client to attain or retain the capability for independence or self-care; or screen for preventable disease or disease exacerbation. This limitation includes services that, upon medical review, could not reasonably have been expected to provide more than minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic services not reasonably required to diagnose a presenting problem, whether 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 OAR 410-120-1200 and 410-120-1210.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3830

RULE TITLE: Prioritized List of Health Services

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

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/CSI-HERC/Pages/Prioritized-List.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule, effective January 1, 2020, incorporates by reference the January 1, 2020 Prioritized List, funded through line 471 and including all line items, diagnosis and treatment codes, guideline notes, statements of intent, coding specifications and annotations. This list supersedes the October 1, 2019 Prioritized List for services provided after January 1, 2020, and includes interim modifications reported as required under ORS 414.690(7) and (8).

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065, ORS 414.727

ADOPT: 410-141-3835

RULE TITLE: MCE Service Authorization

NOTICE FILED DATE: 10/21/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Coverage of services is outlined by MCE contract and OHP benefits coverage in OAR 410-120-1210 and 410-120-1160.

(2) A member may access urgent and emergency services 24 hours a day, seven days a week without prior authorization.

(3) The MCE may not require a member to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. A member may self-refer to behavioral health and services available from the provider network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.

(4) Contractors must permit out-of-network IHCPs to refer an MCE-enrolled American Indian/Alaska Native to a network provider for covered services as required by 42 CFR 438.14(b)(6).

(5) The MCE shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-3830.

(6) MCEs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(7) MCEs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. MCEs shall observe required timely access to service timelines as indicated in OAR 410-141-3515.

(8) MCEs may place appropriate limits on a service authorization based on medical necessity and medical appropriateness as defined in OAR 410-120-0000 or for utilization control provided that the MCE:

(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

(b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;

(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20 and the member's free choice of provider consistent with 42 USC §1396a(a)(23)(B) and 42 CFR §431.51; and

(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.

(9) For authorization of services:

(a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:

(A) For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:

(i) The member, the member's representative, or provider requests an extension; or

(ii) The MCE justifies to the Authority upon request a need for additional information and how the extension is in the

member's interest.
(B) For notices of adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination takes effect:
(i) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;
(ii) The MCE may extend the 72-hour period up to 14 days if the member requests an extension or if the MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.
(b) Prior authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the MCEs as follows:
(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. An initial response shall include:
(i) A written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing practitioner, and when known to the MCE, the pharmacy; or
(ii) A written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved; or
(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the MCE's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or
(iv) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay a decision to approve or deny the drug within 72 hours.
(B) The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug;
(C) If the response is a request for additional documentation, the MCE shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:
(i) Upon receiving the MCE's completed prior authorization forms and required documentation, the MCE shall issue a decision as expeditiously as the member's health requires, but no later than 72 hours from the date and time stamp of the initial request for prior authorization as follows:
(I) If the drug is approved as requested, the MCE shall notify the member in writing and prescribing practitioner, and when known to the MCE, the pharmacy, telephonically, or electronically; or
(II) If the drug is denied or partially approved, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.
(ii) If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.
(D) The MCE shall provide approved services as expeditiously as the member's health condition requires;
(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the MCE makes a coverage decision.
(c) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;
(d) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;

(e) MCEs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR §438.404 and OAR 410-141-3885;
(f) The MCE and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:
(A) MCEs shall consult with the requesting provider for medical services when necessary:
(i) Requesting all the appropriate information to support decision making as early in the review process as possible; and
(ii) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.
(B) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:
(i) Deny a service authorization request;
(ii) Reduce a previously authorized service request; or
(iii) Authorize a service in an amount, duration, or scope that is less than requested.
(C) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify timeframes for the following:
(i) Date and time stamping prior authorization requests when received;
(ii) Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid;
(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;
(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;
(v) Providing services after office hours and on weekends that require prior authorization.
(D) An MCE shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to:
(i) Drugs;
(ii) Alcohol;
(iii) Drug services; or
(iv) Care required while in a skilled nursing facility.
(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within 14 days of receipt of the request as set forth in OAR 410-141-3885 unless otherwise specified in OHP program rules:
(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the 14-day period;
(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;
(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.065, ORS 414.610-414.685