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# PERMANENT ADMINISTRATIVE ORDER

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## DMAP 90-2023

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

FILING CAPTION: Remove weekly enrollment references and replace with “next available enrollment date”

EFFECTIVE DATE: 01/01/2024

AGENCY APPROVED DATE: 12/19/2023

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RULES:
410-141-3805, 410-141-3810, 410-141-3815

AMEND: 410-141-3805

NOTICE FILED DATE: 08/25/2023

RULE SUMMARY: Deleting language around effective date of enrollment under 7(a) and 7(b) to include how members will be enrolled on the next available enrollment date by delivering enrollment lists to CCOs every business day rather than a weekly enrollment list each Monday. Modified definitions and MCE exclusion updated to support the end of the Citizenship Waived Medical program and expansion of the Healthier Oregon program.

CHANGES TO RULE:

410-141-3805
Mandatory MCE Enrollment Exceptions
(1) In addition to the definitions in OAR 410-120-0000, the following definitions apply:¶
(a) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;¶
(b) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;¶
(c) "Renewal" means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status;¶
(d) "~~Citizenship Waived Medical (CWM)" means any of the benefit packages described in OAR 410-134-0003;¶~~
~~(e) "HOP Child", "HOP non-pregnant Adult", and "HOP pregnant Adult"~~Healthier Oregon" and "Healthier Oregon Cover All Kids" means the benefit packages described in OAR 410-134-0003;¶
(e) Compact of Free Association (COFA) Dental Program means the benefit package described in OAR 410-120-1210;(f) Veteran Dental Program means the benefit package~~s~~ described in OAR 410-1~~34-0003;¶~~
~~(f) Compact of Free Association (COFA~~20-1210.¶
(f) "Citizenship Waived Medical (CWM) ~~D~~Ben~~tal Programe~~fits Package" means the benefit package described in OAR 410-1~~20-1210;¶~~
~~(g) Veteran Dental Program means the benefit package described in OAR 410-120-1210~~34-0005(2), which ended on June 30, 2023;¶

(g) "Citizenship Waived Medical Plus (CWM) Benefit Package" means the benefit package described in OAR 410-134-0005(2), which was previously referred to as CWX and ended on June 30, 2023.¶
(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 dental services, which is the CCOA plan type;¶
(b) The member shall be enrolled with a CCO for physical health and behavioral health services and shall remain fee-for-service (FFS) for dental services, which is the CCOB plan type;¶
(c) The member shall be enrolled with a CCO for behavioral health and dental services and shall remain FFS for physical health services, which is the CCOG plan type;¶
(d) The member shall be enrolled with a CCO for behavioral health services and shall remain FFS for physical health services and dental services, which is the CCOE plan type;¶
(e) The member shall be enrolled with a CCO for dental services and remain FFS for physical health and behavioral health services, which is the CCOF plan type;¶
(f) The member shall remain FFS for health care services if no MCE is available; or¶
(g) Members eligible for the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program benefit packages shall be enrolled in a CCO for dental services. Pharmacy services covered under these benefit packages are Carve-Out Services paid by the Authority through the Oregon Prescription Drug Program.¶
(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.¶
(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.¶
(6) Members who are exempt from physical health services shall receive behavioral health services and dental services through an MCE. The member shall:¶
(a) Be enrolled with a CCO that offers behavioral health and dental services;¶
(b) Be enrolled with a CCO for dental services and shall remain FFS for behavioral health services; or¶
(c) Remain FFS for both behavioral health and dental services if a CCO is not available.¶
(7) ~~The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:¶~~
~~(a) On or before Wednesday, the date of enrollment shall be the following Monday; or~~If the member qualifies for enrollment into an MCE and submits a CCO preference, the following pertains to the effective date of the enrollment:¶
(a) The Authority shall provide the enrollment list to MCEs on the next business day following eligibility, redetermination, or upon review by the authority. When eligibility, redeterminations, or reviews occur on a Saturday or Sunday, MCEs shall receive the enrollment list on Tuesday.¶
(b) The effective date of enrollment occurs within two business days after the MCE receives the enrollment information. ¶
(c) If a member is required to enroll and does not express preference, the Authority shall auto assign, and the effective date of enrollment occurs during the next weekly enrollment cycle.¶
(~~b~~d) ~~After Wednesday, the date of enrollment shall be one week from the following Monday~~Newly eligible members that qualify for MCE enrollment shall receive health care services on a fee-for service (FFS) basis until they are enrolled into an MCE.¶
(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:¶
(a) A newborn's enrollment shall begin on the date of birth if the mother was a member of a CCO and the newborn is OHP eligible at the time of birth;¶
(b) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.¶
(9) The following populations may not be enrolled into an MCE, as indicated below in this rule, for any type of health care coverage or for the type of coverage specified:¶
(a) Individuals ~~who are non-citizens and eligible for any of the CWM benefit packages described in OAR 410-134-0003, who are not~~ eligible for OHP through the Healthier Oregon ~~(HOP) Children, HOP non-pregnant Adult, or~~

~~HOP pregnant Adult benefit package described in OAR 410-134-0003;~~¶
~~(b) Individuals eligible for OHP through the HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package~~or Healthier Oregon Cover All Kids benefit package described in OAR 410-134-0003, but for whom the Authority has not provided capitation or other payment rates in the applicable CCO contract;¶
(~~c~~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;¶
(~~d~~c) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE);¶
(d) Before June 30, 2023, individuals eligible for CWM or CWX (CWX began being referred to as CWM Plus effective July 1, 2023) benefit packages described in OAR 410-134-0005(2). ¶
(10) Individuals currently enrolled with an Indian Managed Care Entity (IMCE) consistent with OAR 410-146-5000 may not also be enrolled in the CCOA or CCOB plan type.¶
(11) If enrollment action coincides with an individual's Continuous Inpatient Stay as defined in OAR 410-141-3500, the following enrollment rules apply:¶
(a) A newly eligible OHP client who became eligible while admitted as an inpatient is exempt from all levels of CCO enrollment, except for newborn enrollments in accordance with OAR 410-141-3805(8)(a). The newly eligible OHP client shall receive health care services on a Fee-For-Service (FFS) basis until the individual is discharged from the continuous inpatient stay;¶
(b) In settings where the CCO is fully responsible for covered services, such as an acute care hospital, acute care psychiatric hospital, skilled nursing facility specific to the Post-Hospital Extended Care (PHEC) benefit, Psychiatric Residential Treatment Facility (PRTF), or a residential Behavioral Health or Substance Use Disorder treatment facility that is not considered a Home and Community-Based Services (HCBS) setting as described in OAR 410-173-0035:¶
(A) The CCO is responsible for covered services if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made until the member is discharged from their continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment ~~wi~~shall be cancelled as never effective and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion;¶
(C) When a justice-involved individual, meeting the definition for Inmate stated within OAR 410-200-0015, is admitted to an inpatient setting with an expected stay of at least 24 hours, the individual temporarily resumes OHP eligibility and the inpatient stay is covered by FFS; CCO enrollment shall be the next available enrollment date following release from the penal facility as consistent with OAR 410-200-0140, OAR 461-135-0950, and OAR 410-141-3810, and based on the service area of the member's current permanent residence.¶
(c) In settings where the CCO is responsible for care coordination but not health services, including, but not limited to Medicaid-Funded Long Term Services and Supports (LTSS) or Behavioral Health Carve-Out Services:¶
(A) Contractor is responsible for care coordination if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the member is discharged from their continuous inpatient stay to ensure continuity of care coordination;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment ~~wi~~shall be cancelled as never effective, and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care coordination;¶
(C) When a resident of a public institution, as defined in OAR 461-135-0950, is voluntarily or involuntarily admitted to the Oregon State Hospital, OHP eligibility is suspended and any associated CCO enrollment is ended with an effective date of the inpatient admission; however, the CCO is responsible for care coordination.¶
(d) If an individual is currently experiencing an extended but temporary hold within an Emergency Department due to unavailability of inpatient placement or delay in secure transportation to a facility that can evaluate appropriate psychiatric referrals, no enrollment changes shall be made (CCO-to-FFS or CCO-to-CCO) until the individual is no longer in the Emergency Department or, if subsequent action is admission to an inpatient setting, until the individual is discharged from their continuous inpatient stay.¶
(12) A client may not be enrolled with a CCO in the CCOA, CCOB, CCOE, or CCOG plan type if the client is covered under a major medical insurance policy, Third Party Liability (TPL), or other Third-Party Resource (TPR) that covers the cost of services to be provided by a CCO as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800:¶
(a) A client shall be enrolled with a CCO in the CCOF plan type for dental services even if they have a dental TPR;¶
(b) At the Authority's discretion, a client shall be enrolled with the highest level of CCO coverage, including

physical health, behavioral health, and dental services, if coverage through the TPR poses a safety risk to the member, specific to Good Cause determination as described in OAR 461-120-0350(1) and OAR 410-200-0220(6). In these situations:¶
(A) Recovery of third-party insurance sh~~ould~~all not be pursued; and¶
(B) Explanation of Benefits (EOB) sh~~ould~~all be suppressed.¶
(13) Individuals who are American Indian and Alaskan Native (AI/AN) beneficiaries per OAR 410-141-3500(41) are exempt from mandatory enrollment into an MCE, except for IMCE enrollment per OAR 410-146-5000. ¶
(14) 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 dental services as available in the member's service area unless:¶
(a) Access to health care on an FFS basis is not available; or¶
(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.¶
(15) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:¶
(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;¶
(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise, the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;¶
(c) A full Medicare and Medicaid dually eligible member may request to opt out of enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and dental services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:¶
(A) Access to health care on an FFS basis is not available; or¶
(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority ~~wi~~shall 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 OAR 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.¶
(16) 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.¶
(17) 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 ~~week~~daily enrollment list produced by the Authority;¶
(B) The individual presents a valid medical care identification that shows they are enrolled with the MCE;¶
(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the MCE;¶
(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the MCE.¶
(d) MCEs shall have open enrollment for thirty (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 fourteen (14) months apart.¶
(18) 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 ~~wi~~shall have thirty (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.¶
(19) 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 ninety (90) calendar days written notice ~~prior to~~before the planned effective date of such activity:¶
(a) An MCE may provide less than the required ~~90-~~ninety (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-~~ninety (90) calendar-day notice;¶
(b) The MCE shall provide members with at least a ~~30-~~thirty (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 thirty (30) calendar days ~~prior to~~before the planned effective date of such activity.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3810

NOTICE FILED DATE: 08/25/2023

RULE SUMMARY: Removing references to weekly enrollment and replaced with “next available enrollment date".

CHANGES TO RULE:

410-141-3810
Disenrollment from MCEs
(1) Member-initiated requests for disenrollment.¶
(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule;¶
(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:¶
(A) Without cause:¶
(i) Members may request to change their MCE enrollment within thirty (30) calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur ~~during~~on the next ~~weekly~~available enrollment ~~cycl~~date;¶
(ii) Members may request to change their MCE enrollment within ninety (90) calendar days of the initial MCE enrollment. If approved, the change would occur ~~during~~on the next ~~weekly~~available enrollment ~~cycl~~date;¶
(iii) Members may request to change their MCE enrollment after they have been enrolled with the MCE for at least six (6) 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 MCE does not cover the service the member seeks;¶
(iii) When the member needs related services (for example a Caesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.¶
(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to FFS at any time subject to the provisions set forth in OAR 410-141-3805(14)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition;¶
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include but are not limited to:¶
(i) The member is an American Indian or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the FFS delivery system;¶
(ii) The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member for a provider of a treatment, service, or supply:¶
(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary MCE exemption;¶
(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the member's administrative hearing rights;¶

(E) If thirty (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 ~~wi~~shall 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 MCE within the past three (3) months; or¶
(iii) The member is enrolled with a new 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 sixty (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 MCE in their service area. Where there is a choice among multiple MCEs in the member's service area the~~y~~ member may choose an open plan; however, if the member does not express ~~a~~ preference ~~to OHP, OHP wi,~~ the Authority shall auto assign on a next weekly basis.¶
(d) Upon approval of a member's disenrollment from a MCE, the member shall join another MCE unless:¶
(A) The member resides in a service area where enrollment is voluntary;~~.~~¶
(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805;~~.~~¶
(C) The member meets disenrollment criteria stated in this rule; or¶
(D) There is not another MCE available and open to new enrollment in the service area.¶
(2) MCE-initiated disenrollment requests: MCEs may request disenrollment for any of the reasons in subsection (2)(a) of this rule. Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified in this subsection (2)(a) of this rule. After review of all necessary documentation submitted with an MCE's request, the Authority ~~wi~~shall grant such requests, except the Authority may deny requests based on the reason set forth in subparagraph (G) below:¶
(a) If the individual is enrolled after the first day of admission to an inpatient setting, the enrollment ~~wi~~shall be cancelled as never effective and the individual shall be enrolled in a MCE on the next available enrollment date following discharge from the continuous inpatient stay. This does not apply if the member is a newborn child born to an OHP eligible mother enrolled with a MCE at time of birth in accordance with OARs 410-141-3500 and 410-141-3805;¶
(b) If the MCE determines the member has Third Party Liability (TPL), the MCE shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The MCE shall receive an emailed tracking number following the online report. The MCE may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, the member shall be disenrolled from the MCE effective at the end of the month the TPL is reported, with the exception of:¶
(A) When Good Cause determination is active or concurrently documented, in which case the member ~~wi~~shall retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(B) Some situations in which the Authority may approve retroactive disenrollment;¶
(C) When the client has dental TPR and is enrolled in the CCOF plan type.¶
(c) If a member has been residing outside the MCE's service area for more than three (3) 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 (3) 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 ~~wi~~shall notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;¶
(d) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal facility. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;¶
(e) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution;¶
(f) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time

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

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

threat of violence and the actions taken by the provider as a result;¶
(C) MCEs shall require their providers to document the incident in the member's medical record and the MCE shall document the provider's notice in the member's case file.¶
(d) The MCE shall notify the member's care team of the act or credible threat of violence. The MCE shall involve the member's care team and, within the laws governing confidentiality, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior;¶
(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence;¶
(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes listed in section (4) of this rule prior to making any request for disenrollment;¶
(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (5)(d) of this rule, by following the process set forth in section (4) of this rule, the MCE shall have the right to request the member's disenrollment. The MCE's disenrollment request shall comply with all of the requirements set forth in section (4)(g) of this rule and shall also comply with all additional requirements as follows:¶
(A) Include an explanation of why the MCE believes the exception to following the process explained in section (4) of this rule is necessary as it relates to an act of, or credible threat of, physical violence; and¶
(B) In addition to all other documentation required to be submitted under section (4) of this rule, the request must also include a copy of the police report or case number. If a police report or case number is not available, the MCE shall submit a copy of the provider's entry in the member's medical record, which must be signed by the provider, or a copy of the MCE's entry into the member's case file signed by the applicable MCE personnel, or both, that documents the report to law enforcement or any other reasonable evidence.¶
(6) Approval or Denials of MCE Requests for Disenrollment Due to Uncooperative or Disruptive Behavior, Acts of Violence, or Credible Threats of Violence.¶
(a) MCE requests made without all documentation, including CCO AR requests for additional or clarifying information, required under sections (4) and (5) of this rule shall be denied:¶
(A) When there is insufficient documentation submitted with a request for disenrollment, the CCO AR shall notify the MCE of the denial within two (2) 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 ~~wi~~shall 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 ~~wi~~shall document the review, recommendations, and rational with relevant regulatory or clinical criteria made by the disenrollment review team:¶
(A) The CCO AR shall provide the documentation and recommendations made by the disenrollment review team to Authority's management for a decision regarding disenrollment of the affected member;¶
(B) The documentation provided to Authority management by the CCO AR shall also include the name of all disenrollment review team members, their respective areas of expertise, licensure or certification, or both;¶
(C) The decision, and all individuals involved in making the decision to approve or deny an MCE request for disenrollment under ~~this~~ section (6) of this rule shall be documented in the affected member's case file maintained by the Authority.¶
(d) The CCO AR shall provide written notice on Authority letterhead to the MCE of the Authority's decision to approve or deny the MCE's request for disenrollment. The CCO AR shall provide copies of the notice to the MCE CEO, MCE COO, and the Authority Medicaid Director:¶
(A) All notices of disenrollment approvals and denials shall include the reason for the decision along with applicable, supporting regulatory or clinical criteria, or both, and identify the subject matter expertise and credentials of the disenrollment review team. However, the names of the individuals on the disenrollment review team shall not be included in the notice;¶
(B) When there is sufficient documentation for the CCO AR to convene a disenrollment review team, the notice of approval or disapproval of the request for disenrollment shall be made by the Authority within fifteen (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 (5) business days after the Authority has approved the MCE's request for disenrollment. A copy of the member notice shall be sent to the MCE, which the MCE shall distribute to the member's care team. A copy of the member notice shall be placed in the member's case file maintained by the Authority. The notice of disenrollment provided to the

member shall include all of the following information:¶
(A) The disenrollment date;¶
(B) The reason for disenrollment;¶
(C) Information regarding the member's right to file a grievance and their administrative hearing rights; and¶
(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in the Authority's record of the request and provided to the MCE for distribution the member's care team.¶
(f) The date of disenrollment shall be effective ten calendar days after the date of the member's disenrollment notice, unless:¶
(A) The member files a grievance or otherwise requests a hearing, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon such decisions; or¶
(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE ~~wi~~shall be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.¶
(7) Enrollment for Authority Approved Disenrollment.¶
(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or¶
(b) When circumstances permit, and there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or¶
(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR ~~wi~~shall place an enrollment exemption for the appropriate MCE CCOA, CCOB, CCOE, CCOF, and CCOG plans and place the member on Open Card for a twelve (12) month period, after which the CCO AR ~~wi~~shall 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 414.611, 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) of this rule 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 ninety (90) calendar days before the scheduled date of the transfer.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065, ORS 414.727

AMEND: 410-141-3815

NOTICE FILED DATE: 08/25/2023

RULE SUMMARY: Removing references to weekly enrollment and replaced with “next available enrollment date."

CHANGES TO RULE:

410-141-3815
CCO Enrollment for Temporary Out-of-Area Behavioral Health Treatment Services
(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 ~~wi~~shall, upon the next ~~weekly~~available enrollment ~~period~~date, 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 2023 (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 OAR 410-141-3860. This shall provide for an adequate transition to the next responsible CCO.
Statutory/Other Authority: ORS 413.042, ORS 414.610 - 414.685
Statutes/Other Implemented: ORS 413.042, ORS 414.610 - 414.685