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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) 3840-3965

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RULES:
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ADOPT: 410-141-3840

RULE TITLE: Emergency and Urgent Care Services

NOTICE FILED DATE: 10/18/2019

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 have written policies, procedures, and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all members. CCOs shall:
(a) Communicate these policies and procedures to participating providers;
(b) Regularly monitor participating providers' compliance with these policies and procedures; and
(c) Take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.
(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or orally appropriate response as indicated to urgent or emergency calls including but not limited to the following:
(a) Telephone or face-to-face evaluation of the member;
(b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;
(c) Development of a course of action;
(d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of

a member requiring behavioral health services, or a member who cannot be transported or is homebound;
(e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and
(f) Provision for notifying other providers that prior authorization is required for post-stabilization care in accordance with this rule.
(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.
(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:
(a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;
(b) The CCO may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;
(c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not timely billed for the service.
(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, whether for physical, behavioral, or oral health, whether in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:
(a) Pre-authorized by the CCO;
(b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or
(c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.
(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:
(a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's care;
(b) The participating provider assumes responsibility for the member's care through transfer;
(c) A CCO representative and the treating provider reach an agreement concerning the member's care; or
(d) The member is discharged.
(7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for oral health care:
(a) CCOs shall educate members about, and support them in, how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;
(b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.
(8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3845

RULE TITLE: Health-Related Services

NOTICE FILED DATE: 10/18/2019

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 goals of health-related services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services:

(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below;

(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;

(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;

(d) HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 45 C.F.R. § 158.150:

(a) The service must be designed to:

(A) Improve health quality;

(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(D) Be based on any of the following:

(i) Evidence-based medicine; or

(ii) Widely accepted best clinical practice; or

(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;

(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(D) Implement, promote, and increase wellness and health activities;

(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(c) The following types of expenditures and activities are not considered HRS:

(A) Those that are designed primarily to control or contain costs;

(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;

(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health

information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;
(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;
(F) All retrospective and concurrent utilization review;
(G) Fraud prevention activities;
(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
(I) Provider credentialing;
(J) Costs associated with calculating and administering individual member incentives; and
(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.
(3) CCOs shall implement policies and procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval:
(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability;
(b) A CCO's HRS spending on community benefit initiatives shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any HRS community benefit initiative spending priorities identified by the Authority;
(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in community benefit initiatives spending decisions;
(d) CCOs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.
(4) Flexible services are cost-effective services offered to an individual member as an adjunct to covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care. These services shall be documented in the member's treatment plan and clinical record:
(a) CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;
(b) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915.
(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality. CCOs shall designate a role for the community advisory council in directing, tracking, and reviewing community benefit initiatives, as provided in OAR 410-141-3735.
(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).
(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042

ADOPT: 410-141-3850

RULE TITLE: Transition of Care

NOTICE FILED DATE: 10/18/2019

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 care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after disenrollment from a "predecessor plan," which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). This rule does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.

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

(a) "Continued Access to Care" means, during a member's transition of care from the predecessor plan to the receiving CCO, providing access without delay to:

(A) Medically necessary covered services;

(B) Prior authorized care;

(C) Prescription drugs; and

(D) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.

(b) "Medically Fragile Children" as defined by OAR 411-350-0020 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);

(c) "Prior Authorized Care" means covered services that were authorized by the predecessor plan. This term does not, however, include health-related services approved by the predecessor plan;

(d) "Transition of Care" means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to care. The transition of care period lasts for:

(A) Ninety days for members who are dually eligible for Medicaid and Medicare; or

(B) For other members, the shorter of:

(i) Thirty days for physical and oral health and 60 days for behavioral health; or

(ii) Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan.

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

(a) Medically Fragile Children;

(b) Breast and Cervical Cancer Treatment program members;

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

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

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

(4) Receiving CCO obligations during the transition of care period:

(a) The receiving CCO shall ensure that any member identified in section (3) has continued access to care and Non-Emergency Medical Transportation (NEMT);

(b) The receiving CCO shall permit the member to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's network, until one of the following occurs:

(A) The minimum or authorized prescribed course of treatment has been completed; or
(B) The reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider.
(c) Notwithstanding section (4)(b), the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:
(A) Prenatal and postpartum care;
(B) Transplant services through the first-year post-transplant;
(C) Radiation or chemotherapy services for the current course of treatment; or
(D) Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.
(d) Where this section (4) allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates;
(e) The receiving CCO is not responsible for paying for inpatient hospitalization or post hospital extended care for which a predecessor CCO was responsible under its contract.
(5) After the transition of care period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.
(6) A receiving CCO shall obtain written documentation as necessary for continued access to care from the following:
(a) The Authority's clinical services for members transferring from FFS;
(b) Other CCOs; and
(c) Previous providers, with member consent when necessary.
(7) During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization of ongoing covered services:
(a) CCOs shall not delay service authorization for the covered service if written documentation of prior authorization is not available in a timely manner;
(b) In such instances, the CCO is required to approve claims for which it has received no written documentation during the transition of care time period, as if the covered services were prior authorized.
(8) The predecessor plan shall comply with requests from the receiving CCO for complete historical utilization data within seven calendar days of the request from the receiving CCO.
(a) Data shall be provided in a secure method of file transfer;
(b) The minimum elements provided are:
(A) Current prior authorizations and pre-existing orders;
(B) Prior authorizations for any services rendered in the last 24 months;
(C) Current behavioral health services provided;
(D) List of all active prescriptions; and
(E) Current ICD-10 diagnoses.
(9) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR §438.404 and OAR 410-141-3885.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3855

RULE TITLE: Pharmaceutical Services

NOTICE FILED DATE: 10/18/2019

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) Prescription drugs are a covered service for conditions that are described in the funded region of the Prioritized List of Health Services, as described in OAR 410-141-3820. MCEs shall pay for covered prescription drugs except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants) (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to section (10) of this rule;

(c) Drugs covered under Medicare Part D when the member is fully dual eligible; and

(d) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act, for which payment is governed by OAR 410-121-0150.

(2) MCEs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.

(3) MCEs may use a preferred drug list if it allows access to other drug products not on the drug list through prior authorization.

(4) As specified in 45 CFR 156.122 and 42 CFR 438.10, MCEs shall publish up-to-date, accurate, and complete preferred drug lists, including any tiering structures, that have been adopted and any coverage criteria or other restrictions on the way certain drugs may be obtained. MCEs shall ensure that:

(a) The preferred drug list is easily accessible to members and potential members, state and federal government, and the public;

(b) The preferred drug list is accessible on the MCE's public website in a machine-readable format through a clearly identifiable web link or tab without requiring a member to access account or policy number;

(c) Be made available in paper form if requested by a member; and

(d) If an MCE has more than one plan, members may be easily able to discern which preferred drug list applies to which plan.

(5) The preferred drug list shall:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(6) MCEs shall cover at least one form of contraception within each of the 18 methods identified by the FDA. As set forth in OAR 410-141-3515, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating providers.

(7) Prior authorization for prescription drug requests shall be addressed by the MCEs as described in OAR 410-141-3835.

(8) MCEs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.

(9) MCEs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE)

drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the federal "Drug Products in the Medicaid Drug Rebate Program" list available at: https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e

(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121), unless otherwise provided in this rule. An MCE may not reimburse providers for carved-out drugs:

(a) An MCE may seek to add drugs to the carve-out list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all the following information:

(A) The drug name;

(B) The FDA approved indications that identify the drug may be used to treat a severe mental health condition; and

(C) The reason the Authority should consider this drug for carve out.

(b) If the Authority approves an MCE request for a drug not to be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.

(11) MCEs shall submit quarterly encounter data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.

(12) MCEs are encouraged to provide payment only for outpatient and physician-administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. MCEs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

(13) MCEs shall utilize a pharmacy and therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, if all committee requirements for both committee types are met:

(a) A P&T committee must maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR § 156.122(3)(i) and (ii). Meetings shall be held at least quarterly;

(b) MCEs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations;

(c) The committee in its DUR capacity shall assure prescriptions are appropriate, medically appropriate, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined and described by 42 CFR 456, subpart K and Section 1902(oo) of the Social Security Act [42 U.S.C. 1396a(oo)].

(14) As required by ORS 414.328, CCOs shall implement a synchronization policy for the dispensing of prescription drugs to members of the CCO. A "synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610–414.685

ADOPT: 410-141-3860

RULE TITLE: Integration and Coordination of Care

NOTICE FILED DATE: 10/18/2019

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 order to achieve the objectives of providing CCO members integrated person-centered care and services, CCOs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs shall be required to document and report on the requirements in this rule in accordance with section (20) of this rule.

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

(3) CCOs shall coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:

(a) With the services the member receives from any other CCO, and for FBDE members, from Medicare providers and, where applicable, MA or DSNP plans;

(b) With the services the member receives in FFS Medicaid; and

(c) With the services the member receives from community and social support providers.

(4) CCOs shall develop evidence-based and, whenever possible, innovative flexible and creative strategies, for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.

(5) To the maximum extent feasible, CCOs shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs by:

(a) Making PCPCHs the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) Developing and implementing mechanisms that encourage providers to communicate and coordinate care with PCPCHs in a timely manner, using electronic health information technology when the technology is available; and

(c) Engaging other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.

(6) If, in addition to the use of PCPCH, a CCO implements other models of patient-centered primary health care, the CCO shall ensure member access to effective coordinated care services that include wellness and prevention services, active management and support of members with special health care needs, including those members receiving Medicaid long-term services and supports (LTSS), a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. To that end the CCO shall be required to:

(a) Ensure each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type. If the member does not choose a primary care provider or primary care team within 30 calendar days from the date of enrollment, the CCO shall ensure the member has an ongoing source of primary care appropriate to their needs by formally designating a practitioner or entity. CCOs shall document in each member's case file all efforts made in accordance with this subsection (a);

(b) Ensure that each member has an ongoing source of care appropriate to their needs, including regular access to specialty care for members with chronic conditions or disabilities, and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided with information on how to contact their designated person or entity;
(c) Develop services and supports for primary and behavioral health care that meet the access to care requirements set forth in OAR 410-141-3515 and which are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall also ensure that all other services and supports meet the access to care requirements set forth in OAR 410-141-3515; and
(d) Allow eligible members who are American Indian/Alaska Native to select as their primary care provider:
(A) An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or
(B) An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.
(7) MCEs shall establish and enter into hospital and specialty service agreements that include the role of PCPCHs and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for after-hospital follow up appointments.
(8) CCOs shall meet all of the following requirements relating to transitions of care:
(a) Require hospitals and specialty services to be accountable for achieving successful transitions of care;
(b) Ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings and provided the supportive services needed to ensure successful transition. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, skilled nursing or other long term care settings, and the State Hospital;
(c) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service to a CCO, the CCO shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an CCO participating provider;
(d) Implement systems to assure and monitor transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the processes for members accessing care coordination;
(e) For members who are discharged to post hospital extended care by being admitted to skilled nursing facility (SNF), the CCO shall notify the appropriate Department office and coordinate appropriate discharge planning and ensure services are in place prior to discharge. The CCO shall pay for the full 20-day post-hospital extended care benefit when the full 20 days is required by the discharging provider, if the member was enrolled in the CCO during the hospitalization preceding the nursing facility placement:
(A) CCOs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC) that the post-hospital extended care will be paid for by the CCO;
(B) For members who are discharged to Medicare Skilled Care Unit within a SNF, the CCO shall notify the appropriate Department office when the CCO learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care; and
(C) CCOs shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.
(f) CCOs shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs (as defined under OAR 309-032-0860(30)) between levels or episodes of care. Specific requirements for CCO care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.
(9) CCOs shall work across provider networks to develop partnerships necessary to allow for access to and coordination

with social and support services, including crisis management and community prevention and self-managed programs as follows:
(a) Establishing procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;
(b) Developing and entering into memoranda of understanding (MOUs) or contracts with the local type B Area Agency on Aging or the local office of the Department's APD that details their system coordination agreements regarding members receiving Medicaid-funded LTCSS; and
(c) Developing and entering into MOUs or contracts with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget. For FBDE members, MCEs shall coordinate Medicare covered behavioral health benefits and Medicaid behavioral health benefits to ensure members receive appropriate and medically necessary care, including preventative screenings and assessments.
(10) CCOs shall cover and reimburse inpatient psychiatric services, except when those services are provided at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010 and OAR 410-141-3500. The state may, however, make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services provided at an IMD as an alternative setting to those covered under the state plan, when all of the following requirements are met in accordance with 42 CFR 438.6(e):
(a) The member receiving services is aged 21-64;
(b) The services are provided for a short-term of no more than 15 days during the period of the monthly capitation payment; and
(c) The provision of services at the IMD meets the requirements for "in lieu of services" as set forth in 42 CFR 438.6(e)(2)(i) through (iii), which requires all of the following:
(A) The IMD is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
(B) The CCO must offer members the option to access the state plan services and shall not require members to use the IMD as an alternative service or setting; and
(C) The approved in lieu of services are authorized and identified in the CCO contracts and offered to members at the CCO's option.
(11) If a member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the CCO shall communicate with the member, the member's representative, and the Medicaid funded long-term care provider or facility, and the DHS or AAA case manager about integrated and coordinated care services.
(12) CCOs shall ensure their participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. The CCOs shall also ensure that they facilitate information exchanges between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). Compliance with the requirements under this section (12) shall be documented and reported to the Authority in the form and manner required by the Authority in accordance with OAR 410-141-3525:
(a) CCOs shall require that providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with their Health Equity Plan Training and Education described in 410-141- 3735;
(b) CCOs shall communicate their integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(13) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. CCOs shall coordinate the care of members who enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the Oregon State Hospital and when they are transitioning out of the Oregon State Hospital.
(14) Except as provided in OAR 410-141-3800, CCOs shall coordinate a member's care outside the CCO's service area or, when medically necessary specialty care is not available in Oregon, out-of-state care. CCOs shall coordinate member care even when services or placements are outside the CCO service area. Temporary placements by the Authority, Department, or providers who are responsible for health service placements for services including residential placements, may be located outside the service area; however, the CCO shall coordinate care while in placement and discharge planning for return to the home CCO. For out of service area placements, an exception shall be made for the member to retain home CCO enrollment while the member's placement is a temporary residential placement elsewhere. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan when the member returns to their home CCO; or
(15) CCOs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay for the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 CCO Service Authorization.
(16) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing behavioral health crises and to prevent inappropriate use of the emergency department or jails.
(17) CCOs shall perform care coordination in a manner that is trauma-informed, culturally responsive, and which promotes dignity for individuals with disabilities or chronic conditions, as those terms are defined in OAR 410-141-3500.
(18) CCOs shall implement at least one outcome measure tool for care coordination services at the ICC Care Coordination level. CCOs shall collaborate with the Authority to develop statewide standards for care coordination and ICC.
(19) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a report submitted to the Authority semi-annually. The CCO is subject to appropriate corrective action by the Authority if the contents of the report reveal that the CCO's care coordination requirements are not being met. For each reporting period the report must contain:
(a) Identification of care coordination practices used with members and the frequency with which each of those practices were used;
(b) Identification of the number of members receiving ICC services, the type of ICC services provided, and the demographics of such members;
(c) An overall review of care coordinators performing services for the CCO, separated by employed and delegated or subcontracted care coordinators;
(d) Identification of any significant events that occurred to members, including, without limitation:
(A) Incarceration;
(B) Reassessment triggers; and
(C) Sentinel events;
(e) Data on the type and frequency of reassessment triggers;
(f) Identification of the number of members who received services in coordination with MA or DSNP plans and Medicaid funded LTSS programs and services;
(g) Plans and strategies to improve care coordination with network providers;
(h) Reports of member grievances related to care coordination with corrective action plans to improve common

grievances;

(i) Identification of milestones and accomplishments; and

(j) A plan to improve the overall process of care coordination access for its Members. The plan shall also include discussion of gaps in care coordination services and populations that need additional support and plans for improving the care coordination system within their CCO. The plan is subject to approval by the CCOs' governing boards.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3865

RULE TITLE: Care Coordination Requirements

NOTICE FILED DATE: 10/18/2019

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 will ensure continuous care management for all members.

(2) CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member in accordance with OAR 410-141-3870. This screening is distinct from the assessment of special health care needs:

(a) CCOs must use a universal screening process to evaluate all members for critical risk factors that trigger the need for intensive care coordination for members with special health care needs;

(b) Members shall be screened upon initial enrollment with their CCO. This screening shall be completed as follows:

(A) Within 90 days of the effective date of initial enrollment;

(B) Within 30 days of the effective date of initial enrollment when the member is:

(i) Referred; or

(ii) Receiving Medicaid-funded long-term care, services and supports (LTSS); or

(iii) Is a member of a priority population as such term is defined in OAR 410-141-3870(2); or

(C) Sooner than required under (A) or (B) if required by the member's health condition.

(c) CCOs shall rescreen members annually or sooner if there is a change in health status indicating need for an updated assessment. Members shall be rescreened in accordance with this section (c) even if they have previously declined care coordination or ICC services;

(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;

(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.

(3) CCOs shall document all screenings and assessments in the member's case file:

(a) If a CCO requires additional information from the member to complete a screening or assessment, the CCO shall document all attempts to reach the member by telephone and mail;

(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;

(c) CCOs shall share the results of member assessments and screenings consistent with ORS 414.679 and all other applicable state and federal privacy laws with the following:

(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;

(B) The state or other MCEs serving the member;

(C) Members receiving LTSS and, if approved by the member, their case manager and their LTSS provider, if approved by the member; and

(D) With Medicare Advantage or DSNP plans serving dual eligible members.

(4) CCOs shall have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and for identifying those members requiring referral to the Department for LTSS.

(5) CCOs shall require their care coordinators shall develop, and CCOs shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ICC needs, including those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving LTSS.

(6) A member's care plan must at a minimum:
(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners;
(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member;
(c) Make provision for authorization of services in accordance with OAR 410-141-3835;
(d) For members enrolled in ICC or a condition-specific program, intensive care coordination plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care needs change.
(7) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:
(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;
(b) To ensure engagement and satisfaction with care plans, care coordinators shall:
(A) Actively engage members in the creation of care plans;
(B) Ensure members understand their care plans; and
(C) Ensure members understand their role and responsibilities outlined in their care plans.
(c) Care coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities;
(d) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as above;
(e) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providing the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above.
(8) A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.
(9) Care coordinators shall perform their care coordination tasks in accordance with the following principles:
(a) Use trauma informed, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-being;
(b) Work with members to set agreed-upon goals with continued CCO network support for self-management goals;
(c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;
(d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;
(e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;
(f) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and
(g) Have contact with, if the member is participating in a condition-specific program, the active condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.
(10) Care coordinators shall promote continuity of care and recovery management through:
(a) Episodes of care, regardless of the member's location;

(b) Monitoring of conditions and ongoing recovery and stabilization;
(c) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and
(d) Engaging members, and their family and caregivers as appropriate.
(e) For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.
(11) CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below.
(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities.
(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:
(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;
(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and
(C) Engage with the member, face to face, within two days post discharge.
(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on a face-to-face basis whenever possible, as follows:
(A) Within one business day of admission;
(B) Two times per week while the member is in acute care; and
(C) No less than two times per week within the week of discharge.
(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;
(e) In the event a member has a lapse in Medicaid coverage while admitted to a hospital, residential, inpatient, long-term care, or other similarly licensed in-patient facility, CCOs must also, in addition to providing the services set forth in subsections (a)-(d) of this section (11) of this rule, oversee management of the member's care, work to establish services that may be needed but currently are not available in their service areas, and if eligible, assist in the reinstatement of Medicaid coverage. The CCO's obligation to provide such services shall continue for the period of 60 days from the date the member lost Medicaid coverage or until the member's discharge, whichever occurs sooner.
(12) CCOs shall ensure care coordinators are providing the required and appropriate behavioral, oral, and physical health care services and supports to members. The individual(s) tasked with responsibility for supervising care coordinators, whether employed by a CCO or employed by a Subcontractor providing care coordination services, shall be a licensed master's-level mental health professional. CCOs shall not subcontract or otherwise delegate the responsibility for ensuring any subcontracted care coordination services and activities meet the requirements set forth in this rule, OARs 410-141-3860, 410-141-3870, and any other applicable care coordination requirements.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610–414.685

ADOPT: 410-141-3870

RULE TITLE: Intensive Care Coordination

NOTICE FILED DATE: 10/18/2019

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 are responsible for Intensive Care Coordination (ICC) services. The requirements described in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 and 410-141-3865.

(2) "Prioritized Populations" means individuals who:

(a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;

(b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);

(c) Are children ages 0-5 showing early signs of social/emotional or behavioral problems or have a SED diagnosis;

(d) Are in medication assisted treatment for SUD;

(e) Are women who have been diagnosed with a high-risk pregnancy;

(f) Are IV drug users, have SUD in need of withdrawal management;

(g) Have HIV/AIDS or have tuberculosis;

(h) Are veterans and their families; and

(i) Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

(3) "Intensive Care Coordinator" (ICC Care Coordinator) means a person coordinating ICC services as defined in this rule.

(4) "Intensive Care Coordination Plan" (ICC Plan) means a collaborative, comprehensive, integrated and interdisciplinary-focused written document that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC Services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.

(5) All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children who are members of a prioritized population shall be provided behavioral health services according to presenting needs.

(6) CCOs shall also conduct an ICC assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below in this section (6). All referrals for ICC assessments shall be responded to by the CCO within one business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening. ICC assessments shall be conducted when:

(a) A health risk screening conducted under, and in accordance with, OAR 410-141-3865 indicates a member has special health care needs or other needs or conditions that may indicate a need for ICC services;

(b) A member refers themselves;

(c) A member's representative or provider, including a home and community- based services provider, refers the member; or

(d) Upon referral of any medical personnel serving as a member's LTCSS case manager.

(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC

needs. CCOs shall have established process for responding to all requests for ICC assessments or services, which shall include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one business day.
(8) ICC assessments shall identify the physical, behavioral, oral and social needs of a member.
(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (c)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility revise care plans, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:
(a) For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865 and this rule. Contract shall be made with the member by the ICC care coordinator within three calendar days of receipt of notice of a reassessment triggering event;
(b) Reassessment triggering events include all of the following events:
(A) New hospital visit (ER or admission);
(B) New high-risk pregnancy diagnosis;
(C) New chronic disease diagnosis (includes behavioral health);
(D) New behavioral health diagnosis;
(E) Opioid drug use;
(F) IV drug use;
(G) Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);
(H) New I/DD diagnosis;
(I) Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;
(J) Recent homelessness;
(K) Two or more billable primary Z code diagnoses within one month;
(L) Two or more caregiver placements within past six months;
(M) An exclusionary practice, such as being asked not to return to day care, for children aged
0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;
(N) Discovery of new or ongoing behavioral health needs;
(O) Discharge from a residential setting or long-term care back to the community;
(P) Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;
(Q) Two or more readmissions to an acute care psychiatric hospital in a 6-month period;
(R) Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period; and
(S) Exit from condition-specific program.
(c) Members shall be reassessed for ICC services and care plans or, if applicable, ICC plans shall be revised annually;
(d) Reassessment for ICC services and care plans, or if applicable, ICC plans, revised if necessary, must be performed upon member request.
(10) Members eligible for ICC shall be assigned an ICC care coordinator:
(a) ICC Care coordinator assignments must be made within three business days of determining a member is eligible for ICC services;
(b) If a member is in a condition-specific program at the time they are determined eligible for ICC services, or enters a condition-specific program while receiving ICC services, then the CCO will appoint the care coordinator of the

condition-specific program as the ICC care coordinator for the member while the member is in the condition-specific program. After a member transitions from a condition-specific program, the CCO must reassess the member for ICC services within seven calendar days of the transition and assign a new ICC care coordinator within three business days of the completion of the ICC reassessment;
(c) CCOs shall notify members of their ICC status by at least two means of communication within five business days following the completion of the ICC assessment. Notifications shall include details about the ICC program and the name and contact information of their assigned ICC care coordinator.
(11) CCOs shall implement procedures to share the results of ICC assessment including, without limitation, identifications made as a result of the assessment and intensive care coordination plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.679 and applicable state and federal privacy laws and meet timely access standards set forth in in 410-141-3515.
(12) ICC services shall include, without limitation:
(a) Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;
(b) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;
(c) Assistance to medical providers with coordination of capitated services and discharge planning; and
(d) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
(13) ICC Care coordinators must provide the following services:
(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least once every three months and make other kinds of contact (face to face when possible) three times a month or more frequently if indicated. If an ICC care coordinator is unable to comply with the member contact requirements, the CCO must document attempts made, barriers, and remediation efforts taken to overcome the barriers to the member contact requirements;
(b) Contact the member no more than three calendar days after receiving notification of a reassessment trigger described in section (9) of this rule. If an ICC care coordinator is unable to make contact with the member within three calendar days of a reassessment trigger, the ICC care coordinator must document in the member's case file all efforts made to contact the member. ICC care coordinators must continue brief contacts with members who have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back to the routine contact requirements under subsection (a) of this section (13);
(c) Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care;
(d) Facilitate communication between and among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;
(e) Convene and facilitate interdisciplinary team meetings monthly, or more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7)(d). The ICC care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:

(A) Describe the clinical interventions recommended to the treatment team;
(B) Create a space for the member to provide feedback on their care, self-reported progress towards their ICC plan goals and their strengths exhibited in between current and prior meeting;
(C) Identify coordination gaps and strategies to improve care coordination with the member's service providers;
(D) Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and
(E) Align with the member's individual ICC plan.
(f) Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.
(14) If a member is enrolled in other programs, including condition-specific programs, where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager shall be responsible for supporting specific needs based on their specialty within the interdisciplinary team.
(15) CCOs shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. CCOs shall produce ICC plans for each member requiring ICC services. Each ICC plan shall:
(a) Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTSS providers and the member's participation;
(b) Include consultations with any specialist(s) caring for the member and Medicaid funded long-term services and supports providers and case managers or for full benefit dual eligible (FBDE) members, Medicare providers or MCE aligned Medicare Advantage or Dual Special Needs Plan care coordinators;
(c) Be approved by the CCO in a timely manner if CCO approval is required;
(d) In alignment with rules outlined in OAR 410-141-3835 CCO Service Authorization; and
(e) In accordance with any applicable quality assurance and utilization review standards.
(16) CCOs shall periodically inform all participating providers of the availability of ICC and other support services available for members. CCOs shall also periodically provide training for patient-centered primary care homes and other primary care provider staff.
(17) CCO staff providing or managing ICC care coordination services shall be required to:
(a) Be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the CCO's service areas who are identified as being of a prioritized population;
(b) If a Member is unable to receive services during normal business hours, the CCO shall provide alternative availability options for the member;
(c) Be trained for, and exhibit skills in, person-centered care planning and trauma informed care; and communication with and sensitivity to the special health care needs of priority populations. CCOs shall have a written position description for its staff responsible for managing ICC services and for staff who provide ICC services;
(d) CCOs shall have written policies that outline how the level of staffing dedicated to ICC is determined. The ICC policies must include, without limitation, care coordination staffing standards such that the complexity, scope, and intensity of the needs of members receiving ICC services can be met.
(18) Consistent with the requirements under this rule, CCOs shall make Integration and Care Coordination services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a Member is unable to receive services outside of normal business hours, the CCO shall provide alternative availability options for member.
(19) CCOs shall have a process to provide members with special health care needs who are receiving ICC services or are receiving Medicaid-funded LTSS with direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs. CCOs shall have processes in place to ensure it reviews member needs for LTSS and mechanisms to identify and refer to the Department of human services, inclusive of its area agency on aging, office of developmental disabilities services, and aging and people with disability programs, or,

as may be applicable to a 1915(i) provider for LTSS assessment and services.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3875

RULE TITLE: MCE Grievances & Appeals: Definitions and General Requirements

NOTICE FILED DATE: 10/18/2019

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 definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:

(a) "Appeal" means a review by an MCE, pursuant to OAR 410-141-3890 of an adverse benefit determination;

(b) "Adverse Benefit Determination" means any of the following, consistent with 42 CFR § 438.400(b):

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(B) The reduction, suspension, or termination of a previously authorized service;

(C) The denial, in whole or in part, of payment for a service;

(D) The failure to provide services in a timely manner pursuant to 410-141-3515;

(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;

(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

(c) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;

(d) "Continuing benefits" means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910;

(e) "Grievance" means a member's expression of dissatisfaction to the MCE or to the Authority about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision;

(f) "Member." With respect to actions taken regarding grievances and appeals, references to a "member" include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to MCE notification requirements, a separate notice must be sent to each individual who falls within this definition;

(g) "Notice of Adverse Benefit Determination" means the notice must meet all requirements found at 42 CFR 438.44.

(2) MCEs shall establish and have an Authority approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:

(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;

(b) Member rights to appeal and request an MCE review of a notice of action/adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;

(c) Member rights to request a contested case hearing regarding an MCE notice of action/adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;

(d) An explanation of how MCEs shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;

(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent

response to complaints of violations of consumer rights and protections;
(f) Specific to the appeals process, the policies shall:
(A) Consistent with confidentiality requirements, ensure the MCE's staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;
(B) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;
(C) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;
(D) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and
(E) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.
(3) The MCE shall provide information to members regarding the following:
(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;
(b) Member rights and responsibilities; and
(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.
(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §§ 438.408(b)(1) and (2) and these rules.
(5) Upon receipt of a grievance or appeal, the MCE shall:
(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;
(b) Give the grievance or appeal to staff with the authority to act upon the matter;
(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;
(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:
(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;
(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;
(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.
(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;
(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.
(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.
(8) The following pertains to the release of a member's information:

(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:
(A) Resolving the matter; or
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.
(9) The MCE shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:
(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
(10) The MCE, its subcontractors, and its participating providers may not:
(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
(11) In all MCE administrative offices and in those physical, behavioral, and oral health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:
(a) OHP Complaint Form (OHP 3001);
(b) MCE appeal forms;
(c) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(d) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.
(13) If at the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.
(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;
(b) Monitor the subcontractor's performance on an ongoing basis;
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3880

RULE TITLE: Grievances & Appeals: Grievance Process Requirements

NOTICE FILED DATE: 10/18/2019

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) A member and, with the written consent of the member, a provider or an authorized representative may file a grievance at any time either orally or in writing, on behalf of a member. The grievance may be filed with the MCE or the Authority. If the grievance is filed with the Authority, it shall be promptly forwarded to the MCE.

(2) For standard resolution of a grievance, the MCE shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. The MCE shall:

(a) Within five business days from the date of the MCEs receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or

(b) Promptly, but in no event more than five business days after the date of the MCE's receipt of the grievance, notify the member in their preferred language that there shall be a delay in the MCE's decision of up to 30 days from the date on which the grievance was received by the MCE. The written notice shall specify why the additional time is necessary.

(3) The MCE shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

(4) When informing members of the MCE's decision, the MCE:

(a) May provide its decision related to oral grievances orally but shall also, in call instances respond to oral grievances in writing. Both oral and written responses shall be made in the member's preferred language;

(b) Shall address each aspect of the grievance and explain the reason for the decision;

(c) Shall respond in writing to written grievances in the member's preferred language. In addition to written responses, the MCE may also respond orally in the member's preferred language; and

(d) Shall notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the Authority's Ombudsperson.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, the MCE shall review and report to the Authority, as outlined in the CCO contract, member complaints related to their race and ethnicity, gender identity, sexual orientation, socioeconomic status, country of origin, and disability status.

(6) If an MCE receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another MCE as defined in OAR 410-141-3850, the MCE shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3885

RULE TITLE: Grievances & Appeals: Notice of Action/Adverse Benefit Determination

NOTICE FILED DATE: 10/18/2019

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) When an MCE has made an adverse benefit determination, the MCE shall notify the requesting provider and give the member and the member's representative a written notice of action/adverse benefit determination notice. The notice shall:

(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;

(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule;

(c) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:

(A) Date of the notice;

(B) MCE's name, address, and telephone number;

(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;

(D) Member's name, address, and member ID number;

(E) Service requested or previously provided and the adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment;

(F) Date of the service or date service was requested by the provider or member;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the adverse benefit determination if different from the date of the notice;

(I) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830;

(J) Clear and thorough explanation of the specific reasons for the adverse benefit determination;

(K) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;

(L) The member's or, if the member provides their written consent as required under OAR 410-141-3890(1), the provider's right to file an appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;

(M) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

(N) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;

(O) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and

(P) The member's right to be provided upon request and free of charge, reasonable access to and copies of all

documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination.
(d) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the Oregon's Notice of Action/Adverse Benefit Determination.
(2) The MCE shall provide copies of the following forms when the MCE issues a Notice of Adverse Benefit Determination:
(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(b) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
(3) For requirements of notice of actions/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 reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.
(4) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following:
(a) The MCE may mail the notice no later than the date of adverse benefit determination if:
(A) The MCE has factual information confirming the death of the member;
(B) The MCE receives notice that the services requested by the member are no longer desired or the MCE is provided with information that requires termination or reduction in services:
(i) All notices sent by a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;
(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.
(C) The MCE can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;
(D) The MCE is unaware of the member's whereabouts and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;
(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or
(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.
(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE:
(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and
(B) The MCE has verified those facts, whenever possible, through secondary resources.
(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.
(5) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.

STATUTORY/OTHER AUTHORITY: ORS 414.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3890

RULE TITLE: Grievances & Appeals: Appeal Process

NOTICE FILED DATE: 10/18/2019

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) A member, or a subcontractor or provider with the member's written consent, may file an appeal with the MCE to:

(a) Express disagreement with an adverse benefit determination; or

(b) Contest the MCE's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(2) Appeals may be initiated orally or in writing, subject to the following requirements:

(a) The MCE shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;

(b) The MCE is considered to have satisfied this duty if the MCE has already made attempts to assist the member in filling out the necessary forms to file a written appeal.

(3) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.

(4) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:

(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;

(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.

(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.

(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:

(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;

(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.

(7) Parties to the appeal include, as applicable:

(a) The MCE and the member; or

(b) The MCE and the member's provider.

(8) The MCE shall resolve each standard appeal in time period defined above in section (4). The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.

(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not

furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.

(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

(a) The results of the resolution process and the date the MCE completed the resolution; and

(b) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;

(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and

(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;

(E) Copies of the appropriate forms:

(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or

(ii) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

STATUTORY/OTHER AUTHORITY: ORS 413.032

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3895

RULE TITLE: Grievances & Appeals: Expedited Appeal

NOTICE FILED DATE: 10/18/2019

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) Each MCE shall establish and maintain an expedited review process for appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860.

(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.

(3) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;

(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and

(c) Mail written confirmation of the resolution to the member within three days;

(d) Extend the timeframes by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.

(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(4) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.

(5) If the MCE denies a request for expedited resolution on appeal, the MCE shall:

(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;

(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.

[NOTE: Forms referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3900

RULE TITLE: Grievances & Appeals: Contested Case Hearings

NOTICE FILED DATE: 10/18/2019

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 shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing:

(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures;

(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;

(c) Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.

(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3), below:

(a) The member shall file a hearing request with the Authority using form MSC 0443 or any other Authority-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;

(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's request;

(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:

(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;

(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.

(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:

(A) Date-stamp the hearing request with the date of receipt; and

(B) Submit the following required documentation to the Authority within two business days:

(i) A copy of the hearing request notice of adverse benefit determination, and notice of appeal resolution;

(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.

(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-

003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.

(5) The parties to a contested case hearing include the following:

(a) The MCE and the member; or

(b) The MCE and the member's provider.

(6) The Authority shall refer the hearing request along with the notice of adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date the MCE receives the member's request for appeal. The 90-day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request.

(8) For reversed appeal and hearing resolution services:

(a) For services not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

(b) For services furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3905

RULE TITLE: Grievances & Appeals: Expedited Contested Case Hearings

NOTICE FILED DATE: 10/18/2019

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 shall have a system in place to ensure its members and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.

(3) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with the MCE, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.

(4) Expedited hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(5) The MCE shall submit relevant documentation to the Authority within two working days. The Authority shall decide within two working days from the date of receiving the relevant documentation whether the member is entitled to an expedited contested case hearing.

(6) If the Authority denies a request for an expedited contested case hearing, the Authority shall:

(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and

(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

(7) If a member requests an expedited hearing, the Authority shall request documentation from the MCE, and the MCE shall submit relevant documentation including clinical documentation to the Authority within two working days.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3910

RULE TITLE: Grievances & Appeals: Continuation of Benefits

NOTICE FILED DATE: 10/18/2019

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) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member shall complete an MCE appeal request or an Authority contested case hearing request form and check the box requesting continuing benefits by:

(A) The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;

(c) The benefits shall continue until:

(A) Unless the member requests a contested case hearing with continuing benefits, no later than 10 days following the date of the MCE notice of appeal resolution, a final appeal resolution resolves the MCE appeal;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for a hearing.

(2) For reversed appeal and hearing resolution services:

(a) Benefits not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

(b) Benefits furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the Authority shall pay for those services in accordance with the Authority policy and regulations.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3915

RULE TITLE: Grievances & Appeals: System Recordkeeping

NOTICE FILED DATE: 10/18/2019

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) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.

(2) MCE's must maintain yearly logs of all appeals and grievances for 10 years, which must include information about the reasons for each grievance or appeal, as well as the resolution and supporting reasoning.

(3) The MCE must review the log monthly for completeness, accuracy, and compliance with required procedures.

(4) MCE's shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.

(5) The Grievance System Report and Grievance and Appeals Log shall be forwarded to the MCE's Quality Improvement committee to comply with the Quality Improvement standards as follows:

(a) Review of completeness, accuracy, and timeliness of documentation;

(b) Compliance with written procedures for receipt, disposition, and documentation; and

(c) Compliance with applicable OHP rules.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3920

RULE TITLE: Transportation: NEMT General Requirements

NOTICE FILED DATE: 10/18/2019

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) A CCO shall provide all non-emergency medical transportation (NEMT) services for its members. For purposes of OAR 410-141-3920 to 410-141-3965, references to a "member" include any individual eligible for NEMT services under this section (1) unless context dictates otherwise.

(2) A CCO shall provide a toll-free call center for members to request rides.

(3) Neither a CCO nor any of its Subcontracted transportation providers may bill a member for transport to or from covered medical services, even if the CCO or its contracted transportation provider denied reimbursement for the transportation services.

(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).

(5) A CCO shall have written policies and procedures regarding its NEMT services. The CCO's policies and procedures shall be included in the CCO's Member Handbook, posted on the CCO's website, and included in the CCO's other general information materials. The CCO's written policies and procedures regarding NEMT services shall:

(a) Allow members or their representatives to schedule:

(A) NEMT services up to 90 days in advance;

(B) Multiple NEMT services at one time for recurring appointments up to 90 days in advance; and

(C) Same-day NEMT services.

(b) Comply with the following criteria for member drop-offs and pick-up protocols:

(A) Not permit drivers to drop Members off at an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the member or, as applicable, the Member's guardian, parent, or representative; and

(B) Not permit drivers to pick up Members from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the member, or as applicable, the Member's guardian, parent, or representative; and

(c) Describe passenger rights and responsibilities including the right to file a grievance and request an appeal or reconsideration.

(6) The grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 are available with respect to NEMT services, with the following modifications:

(a) Prior to mailing a notice of adverse benefit determination to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.

(b) The CCO shall mail, within 72 hours of denial, a notice of adverse benefit determination to:

(A) A member denied a ride; and

(B) The provider with which the affected member was scheduled for an appointment provided that the provider is part of the CCO's provider network.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3925

RULE TITLE: Transportation: Vehicle Equipment and Driver Standards

NOTICE FILED DATE: 10/18/2019

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 does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

(2) The CCO shall require all vehicles used for NEMT services to meet the following requirements for the comfort and safety of the members:

(a) The interior of the vehicle shall be clean and free from any debris impeding a member's ability to ride comfortably;

(b) Smoking, aerosolizing or vaporizing of inhalants is prohibited in the vehicle at all times in accordance with ORS 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and

(c) Compliance with all applicable local, state, and federal transportation laws regarding vehicle and passenger safety standards and comfort. All vehicles shall include, without limitation, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) First aid kit;

(C) Fire extinguisher;

(D) Roadside reflective or warning devices;

(E) Flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to securely transport members using wheelchairs or stretchers in accordance with the Americans with Disabilities Act of 1990 (as amended) (ADA), Section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statute 659A.103.

(3) A preventative maintenance schedule shall be followed for each vehicle that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to, the following equipment:

(a) Side and rearview mirrors;

(b) Horn;

(c) Heating, air conditioning, and ventilation systems; and

(d) Working turn signals, headlights, taillights, and windshield wipers.

(4) Prior to hiring an NEMT driver, the CCO shall require the following:

(a) The driver must have a valid driver license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states;

(b) The driver shall not be included on the exclusion list maintained by the Office of the Inspector General; and

(c) The driver must pass a criminal background check in accordance with ORS 181A.195 and 181A.200, and OAR chapter 257, division 10. If the driver is employed by a mass transit district formed under ORS Chapter 267, the driver must pass a criminal background check in accordance with ORS 267.237 as well as the mass transit district's background check policies. A CCO shall have an exception process to the criminal background check requirement that may allow approval of a driver with a criminal background under certain circumstances. The exception process must include review and consideration of when the crime occurred, the nature of the offense, and any other circumstances to

ensure that the member is not at risk of harm from the driver. Any approvals made through the exception process must be documented and maintained for 10 calendar years, even if the CCO is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three-year retention period.

(5) Drivers authorized to provide NEMT services must receive training on their job duties and responsibilities including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting, and the geographic area in which drivers will provide service;

(b) Completing the National Safety Council Defensive Driving course or equivalent within three months of the date of hire and at least every three years thereafter;

(c) Completing and maintaining certification for Red Cross-approved First Aid, Cardiopulmonary Resuscitation, and blood spill procedures courses or equivalent prior to driving any members;

(d) Completing the Passenger Service and Safety course or equivalent course within three months of the date of hire and at least every three years thereafter;

(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride; and

(f) Understanding of and compliance with all state driving and transportation laws.

(6) Emergency Medical Technicians (EMT) licensed under OAR Chapter 333, Division 265 may be hired as an NEMT driver provided the CCO:

(a) Verifies the individual's EMT license is current, is in good standing with the Authority, and then re-verifies the license annually;

(b) Verifies the EMT is not on the exclusion list maintained by the Office of the Inspector General;

(c) Verifies the EMT has successfully completed the training required under subsections 5(b) and (d) of this rule.

(d) Conducts its own criminal background check on the EMT in accordance with section (4)(c) of this rule; and

(e) Completes the training required under subsection (5)(a).

(7) For authorized out-of-state NEMT services in which the transportation provider solely performs work in the other state and for which the CCO has no oversight authority, the CCO is not responsible for requiring that the subcontractor's vehicle and standards meet the requirements set forth in this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3930

RULE TITLE: Transportation: Out-of-Service Area and Out-of-State Transportation

NOTICE FILED DATE: 10/18/2019

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) A CCO shall provide NEMT services outside the CCO's service area under any and all of the following circumstances:

(a) The member is receiving covered services that are not available, in accordance with OAR 410-141-3515, in the CCO's service area;

(b) The member is receiving covered services outside of Oregon, but the location is contiguous to the CCO's service area and no more than 75 miles from the Oregon border;

(c) The member is receiving in-patient services at a facility outside the CCO's service area due to unavailability within the CCO's service area and the member requires additional covered services within the service area where the inpatient service facility is located; and

(d) The member is receiving covered services outside the State of Oregon because the required covered service is not available within Oregon.

(2) Nothing in this rule prohibits a CCO from providing and paying for NEMT services to allow a client to access other services the CCO authorizes.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3935

RULE TITLE: Transportation: Attendants for Child and Special Needs Transports

NOTICE FILED DATE: 10/18/2019

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 NEMT for children 12 years of age and under who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to members with special physical or developmental needs regardless of age.

(2) Parents or guardians must provide an attendant to accompany these members while traveling to and from covered services and other purposes authorized by the CCO in accordance with OAR 410-141-3930(2) except when:

(a) The driver is a Department of Human Services (Department) volunteer or employee or an Authority employee;

(b) The member requires secured transport pursuant to OAR 410-141-3940 (Secured Transports); or

(c) An ambulance provider transports the member for non-emergent services, and the CCO reimburses the ambulance provider at the ambulance transport rate, per CCO contract or non-contracted rate policy.

(3) NEMT ambulance transports shall have an attendant when the CCO uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) The Department shall establish and administer written guidelines for members in the Department's custody including written guidelines for volunteer drivers. If the Department's requirements or administrative rules differ from this rule, the Department's requirements or administrative rules take precedence.

(5) An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant may also be any adult 18 years or older authorized by the member's parent or guardian.

(6) CCOs shall have the right to require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.

(7) Neither the CCO nor its subcontractor shall bill additional charges for a member's attendant.

(8) The attendant must accompany the member from the pick-up location to the destination and the return trip.

(9) The member's parent, guardian, or adult caregiver shall provide and install safety seats as required by ORS 811.210–811.225. An NEMT driver may not transport a member if a parent or guardian fails to provide a safety seat that complies with state law.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3940

RULE TITLE: Transportation: Secured Transports

NOTICE FILED DATE: 10/18/2019

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) "Secured transport" means NEMT services for the involuntary transport of members who are in danger of harming themselves or others. Secured transports may be used when:

(a) The CCO verified that the secured transporter has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and the secured transporter is able to transport the member who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the member in crisis.

(2) One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

(3) The CCO shall authorize transports to and from OHP covered medical services for an eligible member for court ordered medical services with the following exceptions:

(a) The member is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The member is an inmate of a public institution as defined in OAR 461-135-0950 (Eligibility for Inmates); or

(c) The Authority has suspended the member's OHP eligibility pursuant to ORS 411.439.

(4) The CCO shall assume that a member returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a member to their place of residence, the CCO shall obtain written documentation signed by the treating medical professional stating the circumstances that required secured transport. The CCO shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The CCO may approve and pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing if there is no other source of funding for this transport.

(6) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3945

RULE TITLE: Transportation: Ground and Air Ambulance Transports

NOTICE FILED DATE: 10/18/2019

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) Transporting a member via ambulance is required when a medical facility or provider states the member's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the CCOs shall authorize the transport.

(3) CCOs shall provide ambulance transports with a medical technician when:

(a) A member's medical condition requires a stretcher and the length of transport requires a personal care attendant, but the member does not have one; or

(b) Necessitated by the member's medical condition consistent with section (1) above of this rule.

(4) When a member's medical condition is an emergency as defined in OAR 410-120-0000, emergency ambulance transportation must be used. The ambulance must transport the member to the nearest appropriate facility able to meet the member's medical needs.

(5) CCOs shall verify that providers of ground or air ambulance services have been licensed by the Authority to operate ground or air ambulances. If the ambulance service provider is located in a contiguous state and regularly provides rides to OHP members, the CCO must ensure the ambulance service provider has been licensed by both the Authority and the contiguous state in which it is operating.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3955

RULE TITLE: Transportation: Member Service Modifications and Rights

NOTICE FILED DATE: 10/18/2019

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 the purposes of this rule, "direct threat" means a significant risk to the health or safety of others and which:

(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes; and

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence which shows:

(A) The nature, duration, and severity of the risk;

(B) The probability that a potential injury will actually occur; and

(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.

(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles which shall include, without limitation, policies and procedures that comply with this rule. CCOs shall provide its passenger safety policy and procedures to its NEMT subcontractors and require the NEMT subcontractors to implement and follow such policies and procedures. The CCOs' passenger safety policy and procedures shall be included in their member handbooks and posted on their websites.

(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.

(4) CCOs may not apply criteria, standards, or practices that screen out, or tend to screen out, individuals in a protected class, as defined under state anti-discrimination laws, from fully and equally enjoying any goods, services, programs, or activities unless:

(a) The criteria can be shown to be necessary for providing those goods and services; or

(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.

(5) A CCO may modify NEMT services when the member:

(a) Threatens harm to the driver or others in the vehicle;

(b) Presents a direct threat to the driver or others in the vehicle;

(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm;

(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services;

(e) Frequently does not show up for scheduled rides; or

(f) Frequently cancels the ride on the day of the scheduled ride time.

(6) A member may request modification of NEMT services when the NEMT driver:

(a) Threatens to harm the member or others in the vehicle;

(b) Drives or engages in other behavior that places the member or others in the vehicle at risk of harm; or

(c) Presents a direct threat to the member or others in the vehicle.

(7) Reasonable modifications include, but are not limited to, requiring members to:

(a) Use a specific transportation provider;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive or locate someone to drive the member and receive mileage reimbursement; and

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(8) Members shall be advised at the time of request for NEMT services of the need for accommodation which shall be followed by written confirmation to the member, the member's care coordinator, and any requesting provider. Before modifying services, the NEMT provider, a CCO representative, and the member shall:
(a) Communicate about the reason for imposing a modification;
(b) Explore options that are appropriate to the member's needs; and
(c) Address health and safety concerns.
(9) The communications discussed in section (8) of this rule may include:
(a) The member's care team, including any care coordinator, at the request or upon approval of the member or the CCO;
(b) Any other individual of the member's choosing.
(10) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.
(11) A CCO may not modify NEMT services under this rule unless the modification is permitted under this rule or required in order to accommodate a disability requiring modification or auxiliary aid.
(12) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.
(13) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3960

RULE TITLE: Transportation: Member Reimbursed Mileage, Meals, and Lodging

NOTICE FILED DATE: 10/18/2019

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) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.

(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.

(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. The OHP fee schedule is available on the Authority's website.

(4) The member must return any documentation a CCO requires before receiving reimbursement.

(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.

(6) A CCO shall reimburse members for meals when a member travels:

(a) Out of their local area as outlined in OAR 410-141-3515(4)(a) and (b); and

(b) For a minimum of four hours round-trip.

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.

(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.

(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:

(a) The member is a minor child and unable to travel without an attendant;

(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;

(c) The member is mentally or physically unable to reach their medical appointment without assistance; or

(d) The member is or would be unable to return home without assistance after the treatment or service.

(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCO's discretion.

(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The member; or

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;

(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.

(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

ADOPT: 410-141-3965

RULE TITLE: Reports and Documentation

NOTICE FILED DATE: 10/18/2019

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 maintain documentation of rides denied and rides provided to members.

(2) The CCO shall retain the documentation on NEMT service denials for 10 calendar years, even if the CCO, its brokerage, or subcontractor that denied the service is no longer a Medicaid enrolled provider before the end of the 10 years. The Authority may request this information at any time during the 10-year retention period.

(3) The Authority may request and the CCO shall provide other reports or information not specified in this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625