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PERMANENT ADMINISTRATIVE ORDER

DMAP 28-2026

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

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FILING CAPTION: Update and clarify rules for CCOs, including comprehensive review of service area change rule

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RULES:
410-141-3515, 410-141-3585, 410-141-3720, 410-141-3835, 410-141-3845, 410-141-3920, 410-141-3935, 410-141-3955, 410-141-3960

AMEND: 410-141-3515

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Require CCOs to provide reporting to the Authority on language access and interpreter services according to a new, twice-yearly schedule. Replace MCE (managed care entity) with CCO (coordinated care organization) throughout.

CHANGES TO RULE:

410-141-3515
Network Adequacy
(1) ~~Managed Care Entities (MCEs)~~CCOs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the ~~MCE~~CCO anticipate shall become enrolled as members.¶

(2) The ~~MCE~~CCO shall develop a provider network that enables members to access services within the standards defined in this rule.¶
(3) The ~~MCE~~CCO shall meet access-to-care standards that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.¶
(4) ~~MCE~~CCOs shall meet quantitative network access standards defined in rule and contract.¶
(5) ~~MCE~~CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.¶
(6) In developing its provider network, the ~~MCE~~CCOs shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health conditions, in the most appropriate and independent setting, including in their own home or independent supported living.¶
(7) In assessing the capacity and adequacy of its provider network, ~~MCE~~CCOs shall consider, in conjunction with the quantitative standards set forth in this rule, the variety of provider and facility types with the demonstrated ability and expertise to render specific medically or dentally appropriate covered services within the scope of applicable licensing and credentialling. This includes, but is not limited to, the prescribing of Medication-Assisted Treatment and more specialized oral health care services.¶
(8) All ~~MCE~~CCOs shall ensure 95 percent of members can access the following provider and facility types, further defined by the Authority in guidance made available on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx, within acceptable travel time or distance standards set forth this rule:¶
(a) Tier one:¶
(A) Primary care providers serving adults and those serving pediatrics;¶
(B) Primary care dentists serving adults and those serving pediatrics;¶
(C) Mental health providers serving adults and those serving pediatrics;¶
(D) Substance use disorder providers serving adults and those serving pediatrics;¶
(E) Pharmacy;¶
(F) Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(b) Tier two:¶
(A) Obstetric and gynecological service providers;¶
(B) The following specialty providers, serving adults and those serving pediatrics;¶
(i) Cardiology;¶
(ii) Neurology;¶
(iii) Occupational Therapy;¶
(iv) Medical Oncology;¶
(v) Radiation Oncology;¶
(vi) Ophthalmology;¶
(vii) Optometry;¶
(viii) Physical Therapy;¶
(ix) Podiatry;¶
(x) Psychiatry;¶
(xi) Speech Language Pathology.¶
(C) Hospital;¶
(D) Durable medical equipment;¶
(E) Methadone Clinic;¶
(F) Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(c) Tier three:¶
(A) The following specialty providers, serving adults and those serving pediatrics;¶
(i) Allergy & Immunology;¶
(ii) Dermatology;¶
(iii) Endocrinology;¶
(iv) Gastroenterology;¶
(v) Hematology;¶
(vi) Nephrology;¶
(vii) Otolaryngology;¶
(viii) Pulmonology;¶
(ix) Rheumatology;¶
(x) Urology.¶

(B) Post-hospital skilled nursing facilities;¶
(C) Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(9) All ~~MCE~~CCO acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications. The Authority shall provide tools and additional guidance specific to time and distance monitoring on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶
(a) A CCO service area may contain multiple geographic designations. When calculating travel time and distance, geographic designations ~~shall~~must not overlap and the following definitions of geographic designations shall apply:¶
(A) Large urban area: Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.¶
(B) Urban area: An area with greater than 40,000 people within a 10 mile radius of a city center.¶
(C) Rural area: An area greater than 10 miles from the center of an urban area.¶
(D) County with extreme access considerations: County with a population density of 10 or fewer people per square mile.¶
(b) When calculating travel time and distance, ~~MCE~~CCOs shall use the following standards:¶
(A) Large Urban Area:¶
(i) Tier one: 10 minutes or 5 miles;¶
(ii) Tier two: 20 minutes or 10 miles;¶
(iii) Tier three: 30 minutes or 15 miles.¶
(B) Urban Area:¶
(i) Tier one: 25 minutes or 15 miles;¶
(ii) Tier two: 30 minutes or 20 miles;¶
(iii) Tier three: 45 minutes or 30 miles.¶
(C) Rural Area:¶
(i) Tier one: 30 minutes or 20 miles;¶
(ii) Tier two: 75 minutes or 60 miles;¶
(iii) Tier three: 110 minutes or 90 miles.¶
(D) County with Extreme Access Considerations:¶
(i) Tier one: 40 minutes or 30 miles;¶
(ii) Tier two: 95 minutes or 85 miles;¶
(iii) Tier three: 140 minutes or 125 miles.¶
(10) ~~MCE~~CCOs may request an exception to a standard set in (8) and (9) of this rule. ~~MCE~~CCOs may request multiple exceptions.¶
(a) Exception requests must be submitted in a format provided by the Authority and made available on the CCO Contract Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶
(b) The Authority shall review and approve or deny exception requests based on criteria made available on the CCO Contracts Forms webpage. Approved exceptions must be reviewed at least annually.¶
(11) OHA may grant exceptions to the standards set in (8) and (9) of this rule when enrollment capacity is increased.¶
(12) ~~MCE~~CCOs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:¶
(a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;¶
(b) The number and types of providers required to furnish the contracted services based on the expected utilization of services referenced above and the number and types of providers actively providing services within the ~~MCE~~CCO's current provider network;¶
(c) How the ~~MCE~~CCO shall meet the accommodation and language needs of individuals with LEP as defined in OAR 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;¶
(d) The availability of telemedicine within the ~~MCE~~CCO's contracted provider network.¶
(13) ~~MCE~~CCOs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the ~~MCE~~CCO is unable to provide those

services through the use of participating providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from non-participating providers as geographically close to the member as possible, including providers outside the service area.¶
(14) ~~MCE~~CCOs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or Oregon Youth Authority (OYA) services have access to primary care, oral care (when the ~~MCE~~CCO is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. ~~MCE~~CCOs shall monitor and have policies and procedures to ensure:¶
(a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;¶
(b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.¶
(15) ~~MCE~~CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:¶
(a) Physical health:¶
(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;¶
(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;¶
(C) Well care: Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.¶
(b) Oral and Dental care for children and non-pregnant individuals:¶
(A) Dental Emergency services as defined in OAR 410-120-0000: Seen or treated within 24 hours;¶
(B) Urgent dental l care: Within two (2) weeks;¶
(C) Routine oral care: Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate.¶
(c) Oral and Dental care for pregnant individuals:¶
(A) Dental Emergency services. Seen or treated within 24 hours;¶
(B) Urgent dental care, within one (1) week;¶
(C) Routine oral care: Within four (4) weeks, unless there is a documented special clinical reason that must make access longer than four (4) weeks appropriate.¶
(d) Behavioral health:¶
(A) Urgent behavioral health care for all populations: Within 24 hours;¶
(B) Specialty behavioral health care for priority populations:¶
(i) In accordance with the timeframes listed in this rule for assessment and entry, terms are defined in OAR 309-019-0105, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;¶
(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;¶
(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within fourteen (14) days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;¶
(iv) Opioid use disorder: Assessment and entry within 72 hours;¶
(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;¶
(vi) Children with serious emotional disturbance as defined in OAR 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.¶
(C) Routine behavioral health care for non-priority populations: Assessment within seven days of the request, with a second appointment occurring as clinically appropriate.¶
(16) ~~MCE~~CCOs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or, as detailed in OAR chapter 950, division 050 for those who have Limited English Proficiency, prefer to communicate in a language other than English or who communicates in signed language.¶
(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter

services by phone or in person anywhere the member is attempting to access care or communicate with the ~~MCE~~CCO or its representatives;¶
(b) ~~MCE~~CCOs shall ensure the provision of certified or qualified interpreter services for all covered services to interpret for members with hearing impairment or in the primary language of non-English-speaking members;¶
(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;¶
(d) ~~MCE~~CCOs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. ~~MCE~~CCOs shall ensure the provision of Oregon certified or Oregon qualified interpreters.¶
(e) ~~MCE~~CCOs shall comply with requirements of the Americans with Disabilities Act of 1990, as amended via the ADA Amendments Act of 2008, in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;¶
(f) ~~MCE~~CCOs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;¶
(g) ~~MCE~~CCOs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the ~~MCE~~CCO contract. The Authority shall provide supplemental instructions about the use of any required forms:¶
(A) Using the interpreter services self-assessment reporting template provided by the Authority, ~~MCE~~CCOs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;¶
(B) ~~MCE~~CCOs shall collect and report language access and interpreter services to the Authority ~~quarterly~~ using the report form provided by the Authority. The ~~quarterly~~ due dates for ~~each Report is the first day of each calendar quarter, reporting~~the report are April 1 and October 1 in each calendar year. Each report shall include data for the twelve (12) months ending one quarter before the due date.¶
(C) ~~MCE~~CCOs shall complete and submit to the Authority any other language access reporting that may be required in the ~~MCE~~CCO contract.¶
(17) ~~MCE~~CCOs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the ~~MCE~~CCO and the ~~MCE~~CCO's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. ~~MCE~~CCOs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.¶
(18) ~~MCE~~CCOs must submit a Delivery System Network (DSN) report annually to the Authority that includes access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:¶
(a) Behavioral health access;¶
(b) Interpreter utilization by the ~~MCE~~CCO's provider network;¶
(c) Behavioral health provider network.¶
(19) ~~MCE~~CCOs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).¶
(20) ~~MCE~~CCOs shall implement and require its providers to adhere to the following appointment and wait time requirements:¶
(a) A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they ~~shall~~must not be penalized for failing to keep the appointment;¶
(b) ~~MCE~~CCOs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the ~~MCE~~CCO that the member failed to keep scheduled appointments. The procedures shall address:¶
(A) Timely rescheduling of missed appointments, as deemed medically appropriate;¶
(B) Documentation in the clinical record or non-clinical record of missed appointments;¶
(C) Recall or notification efforts; and¶
(D) Method of member follow-up.¶
(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the ~~MCE~~CCO's participating provider office or clinic, or lack of interpreter services, ~~MCE~~CCOs shall provide outreach services and offer Care Coordination as medically appropriate to make a plan with the member to resolve barriers;¶
(d) Recognition of whether NEMT services were the cause of the member's missed appointment.¶
(21) ~~MCE~~CCOs shall assess the needs of their membership and make available supported employment and

Assertive Community Treatment services when members are referred and eligible:¶
(a) ~~MCE~~CCOs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by the Authority. When no appropriate provider is available, the ~~MCE~~CCO shall consult with the Authority and develop an approved plan to make supported employment and Assertive Community Treatment (ACT) services available;¶
(b) If ten (10) or more members in a ~~MCE~~CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive ACT for more than thirty (30) days, ~~MCE~~CCOs shall notify the Authority and take action to reduce the waitlist and serve those individuals by:¶
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or¶
(B) Adding additional Assertive Community Treatment teams; or¶
(C) When no appropriate ACT provider is available, the ~~MCE~~CCO shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.¶
(22) HRSN Service Provider Minimum Network Requirements.¶
(a) A~~n MCE~~ CCO must offer HRSN Services in all service areas in which the ~~MCE~~CCO operates.¶
(b) The ~~MCE~~CCO must ensure that HRSN Services are delivered to Members within the timelines outlined in OAR 410-120-2020.
Statutory/Other Authority: ORS 413.042, 414.~~615~~572, 414.~~625, 414.635~~591, 414.605~~1~~
Statutes/Other Implemented: ORS 414.~~61~~570 - 414.68~~5~~6

AMEND: 410-141-3585

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Specifies materials CCOs must provide in hardcopy in a member's welcome packet. Allows CCOs to provide directions on accessing a member handbook as part of the welcome packet instead of requiring it in hardcopy. Replace MCE (managed care entity) with CCO (coordinated care organization) throughout.

CHANGES TO RULE:

410-141-3585
~~MCE~~CCO Member Relations: Education and Information
(1) ~~Managed Care Entity's (MCEs)~~CCOs may engage in activities for existing members related to outreach, health promotion, and health education. ~~MCE~~The CCO must obtain approval of the Authority prior to distribution of any written communication by the ~~MCE~~CCO or its subcontractors and providers that:¶
(a) Is intended solely for members; and¶
(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.¶
(2) ~~MCE~~CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. ~~MCE~~CCOs shall address health literacy issues by preparing these documents at a low literacy reading level, incorporating graphics and utilizing alternate formats.¶
(3) ~~MCE~~CCOs shall have a mechanism to help members understand the requirements and benefits of the ~~MCE~~CCO's coordinated care model. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. ~~MCE~~CCOs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.¶
(4) ~~MCE~~CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. ~~MCE~~CCOs shall update their educational material as they add coordinated services. Member education shall:¶
(a) Be made available in the prevalent non-English languages in the ~~MCE~~CCOs service area and provided in alternate formats upon request and free of charge in compliance with 42 CFR 438.10.~~-~~Auxiliary aids and services must also be made available upon request at no cost;¶
(b) Include information about the care coordination approach and how to navigate the coordinated health care system and where applicable for Full Benefit Dual Eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;¶
(c) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 950-060-0010;¶
(d) Inform all members of the availability of Ombudsperson services.¶
(5) Written member materials shall comply with the following language and access requirements:¶
(a) Materials shall be translated in the prevalent non-English languages as defined in OAR 410-141-3575 in the service area as well as include ~~a~~ taglines in large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the ~~MCE~~CCO's member/customer service unit;¶
(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The ~~MCE~~CCO's process for providing alternative formats and auxiliary aids to members m~~ay~~ust not in effect deny or limit access to covered services, grievance, appeals, or hearings;¶
(c) Electronic versions of member materials shall be made available on the ~~MCE~~CCO website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, is searchable and Readily Accessible. For any required member education materials on the ~~MCE~~CCO website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the ~~MCE~~CCO shall provide it upon request within five business days.¶

(6) ~~MCE~~CCO provider directories shall be a single, comprehensive resource that encompasses the ~~MCE~~CCO's entire Provider Network, including any Providers contracted by Subcontractors that serve the ~~MCE~~CCO's Members. ~~MCEs may~~CCOs must not utilize a Subcontractor's separate or standalone provider directory to meet the Provider Directory requirement and shall include:¶
(a) The provider's name as well as any group affiliation;¶
(b) Street address(es);¶
(c) Telephone number(s);¶
(d) Website URL, as appropriate;¶
(e) Provider Specialty, as appropriate;¶
(f) National Provider Identifier (NPI), as appropriate;¶
(g) Whether the provider shall accept new members;¶
(h) Whether the provider offers both telehealth and in-person appointments;¶
(i) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;¶
(j) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶
(k) Narrative space that is optional for providers to list biographical, cultural, linguistic, or other relevant information.¶
(~~L~~l) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on specific accessibility features of provider's offices, exam rooms, and equipment (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, restrooms, grab bars, or other equipment).¶
(m) The information for each of the following provider types covered under the contract, as applicable to the ~~MCE~~CCO contract:¶
(A) Physicians, including specialists, available to members on an outpatient basis and not solely available in a nursing facility or other institutional setting;¶
(B) Hospitals;¶
(C) Pharmacies;¶
(D) Behavioral health providers; including specifying substance use treatment providers;¶
(E) Dental providers;¶
(F) HRSN Service Providers.¶
(n) Information included in the provider directory shall be updated at least monthly, and electronic provider directories shall be updated no later than thirty (30) days after the ~~MCE~~CCO receives updated provider information. Updated materials shall be available on the ~~MCE~~CCO website in a readily accessible and machine-readable file per form upon request and another alternative format.¶
(7) Each ~~MCE~~CCO shall make available in electronic or paper form the following information about its formulary:¶
(a) Which medications are covered both generic and name brand;¶
(b) What tier each medication is on.¶
(8) Within fourteen (14) days of a~~n MCE~~ CCO's receiving notice of a member's enrollment, ~~MCE~~CCOs shall mail a welcome packet to new members and to members returning to the ~~MCE~~CCO twelve (12) months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a ~~member handbook~~n ID card, a Notice of Availability of Language Access, a Notice of Nondiscrimination, and information on how to access a member handbook and a provider directory, including a list of any in-network retail and mail-order pharmacies.¶
(9) For existing ~~MCE~~CCO members, a~~n MCE~~ CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. ~~MCE~~CCOs shall send hard copies upon request within five days. ~~MCE~~CCOs must also notify members of their nondiscrimination policies annually and as otherwise specified in 45 CFR 92.10.¶
(10) ~~MCE~~CCOs must notify enrollees:¶
(a) That interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials are available free of charge to ~~MCE~~CCO members in its health programs and activities as stated in 42 CFR 438.10. This notice must be provided in the manner specified in 45 CFR 92.11;¶
(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;¶
(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.¶
(11) A~~n MCE~~ CCO shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, ~~member handbook~~an ID card, a Notice of Availability of Language Access, a Notice of Nondiscrimination, and information on how to access a member handbook and a provider directory.¶

(12) ~~MCE~~CCOs shall adopt the language in the Authority's Model Member Handbook. ~~MCE~~CCO Member Handbooks shall comply with the Authority's formatting and readability standards.¶
(13) Member health education shall include:¶
(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. ~~MCE~~CCO providers or other individuals or programs approved by the ~~MCE~~CCO may provide health education. ~~MCE~~CCOs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;¶
(b) Information specifying that ~~MCEs shall~~CCOs must not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:¶
(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;¶
(B) Any information the member needs to decide among all relevant treatment options;¶
(C) The risks, benefits, and consequences of treatment or non-treatment.¶
(c) ~~MCE~~CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;¶
(d) An explanation of care coordination and how members may participate in those services. ~~MCE~~CCOs shall ensure that care coordination related education is provided to members with special health care needs as defined in OAR 410-141-3500;¶
(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;¶
(f) ~~MCE~~CCOs shall provide written notice to affected members of any Material Changes to Delivery System as defined in OAR 410-141-3500 or any other significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from ~~MCE~~CCO's participating providers. The ~~MCE~~CCO shall provide, translated as appropriate, the notice at least thirty (30) days before the effective date of that change, or within fifteen (15) calendar days after receipt or issuance of the termination notice if the participating provider has not given the ~~MCE~~CCO sufficient notification to meet the thirty (30) day notice requirement. The Authority shall review and approve the materials within two (2) working days.¶
(14) ~~MCE~~CCOs shall provide an identification card to members, unless waived by the Authority, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the ~~MCE~~CCO, members, and providers.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3720

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Changes resulting from a comprehensive review of the rule that include: 1) Clarification on when the rule applies, 2) Reducing barriers for an existing CCO to take on the service area, 3) An application that relies more on current performance and proximity to the service area, and 4) Replacing discretionary language with specific criteria.

CHANGES TO RULE:

410-141-3720
Service Area Change for Existing CCOs
(1) For purposes of this rule, the following definitions apply:¶
(a) "Applicant" means a coordinated care organization (CCO) as defined in ORS 414.572 with a CCO contract with the Authority that submits an application seeking a contract amendment for a new service area. The CCO is described for purposes of this rule as the applicant upon its submission of the CCO Letter of Intent to Apply;¶
(b) "Document Review" means the review conducted by the Authority, occurring at the point after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant's ability to serve Medicaid beneficiaries in the requested service areas;¶
(c) "Letter of intent to apply (LOIA)" means a letter from a CCO to the Authority stating the CCO's intent to submit a SAC packet in response to a service area need. An LOIA may be binding or non-binding, as specified in the Authority's announcement of the service area need;¶
(d) "SAC packet" means the packet of application documents that the Authority provides to CCOs applying for a ~~SAC;¶~~
~~(e) "S~~service ~~A~~area ~~C~~change~~" or "SAC" means a change in a CCO's s~~ (SAC);¶
(e) "Service ~~a~~Area~~ as specified in the Authority's contract with the CCO;¶~~
~~(f) "Service Area Need~~" has the meaning provided for in OAR 410-141-3500;¶
(f) "Service Area Change Process" or "SAC Process" means ~~w~~then process the Authority ~~identifies a need, as defined in section (3) of this rule, for existing CCOs to apply to the Authority for a SAC to serve~~uses to evaluate and approve CCO requests to expand into a new service area when a service area need exists.¶
(2) A CCO that desires to withdraw from all or a portion of its service area shall ~~make every effort to~~ provide the Authority with a form Letter of Intent to ~~Exit~~Withdraw from the service area at least 1~~5~~20 calendar days prior to the intended date of withdrawal. The template for this form can be found on the CCO Contract Forms page. Partial withdrawals (i.e., withdrawal from only part of the service area) shall be allowed to be effective only upon written approval by the Authority. The Authority shall work with the CCO and any other impacted CCO for a workable ~~exit~~withdrawal transition.¶
(3) ~~The Authority may determine a service area need exists, or is anticipated to exist~~Upon receiving written notice from a CCO of its desire to withdraw from all or part of a service area, the Authority shall acknowledge receipt and commence the withdrawal process defined in the applicable contract and in OAR 410-141-3710 (Contract Termination and Close-Out Requirements).¶
(a) Within a period not to exceed five (5) business days after receipt of the withdrawal notice, ~~w~~then~~ a CCO would no longer be serving all or a portion of its service area.¶~~
~~(4) The Authority shall follow the process set forth in this rule when announcing a need for a SAC:~~ Authority shall notify all contracted CCOs of:¶
(A) The identity of the withdrawing CCO;¶
(B) The geographic boundaries of the affected service area(s);¶
(C) The number of members impacted;¶
(D) The anticipated effective date of the withdrawal; and¶
(E) The opportunity for expansion by contracted CCOs.¶
(b) With the notice of withdrawal to the contracted CCOs, the Authority shall open a fourteen (14) calendar day interest period during which contracted CCOs may submit written notice of interest in expanding into the vacated service area. OHA shall provide instructions for the form and method of submitting interest;¶
(c) CCOs submitting a written notice of interest shall, at minimum:¶
(A) Identify the geographic areas the CCO seeks to serve;¶
(~~a~~B) ~~Within 30 days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for th~~Describe how the CCO will meet network adequacy requirements consistent with OAR 410-141-3515;¶
(C) Outline the CCO's proposed timeline and activities to ensure continuity of care, member protections, and care coordination consistent with OAR 410-141-3860 through 410-141-3870; and¶

(D) Identify any anticipated subcontracting necessary to serve the area, consistent with OAR 410-141-3505.¶
(d) After the interest period closes, the Authority shall review all timely submitted notices of interest to determine the feasibility of service area expansion by one or more interested contracted CCOs. If no CCO submits a notice of interest, or the one or combination of more than one CCOs submitting a notice of interest fails to meet the Authority's criteria for assuming the vacated service area, the Authority shall initiate a service area change (SAC~~. The announcement shall specify when the LOIA is due;¶~~
~~(b) Not later than 15 calendar days from the date of the Authority's notification in section (4)(a) of this rule,~~) process.¶
(4) The Authority shall determine if a service area need exists, or is anticipated to exist, when:¶
(a) A service area, or a portion of a service area, is being served by one CCO and that CCO is withdrawing;¶
(b) A CCO is withdrawing from a service area, or a portion of a service area, that has one or more additional contracted CCOs and the remaining CCO(s) are unable to meet the contractual requirements to serve the service area's population when considering:¶
(A) Access to care;¶
(B) Service delivery;¶
(C) Member rights and health equity; and¶
(D) Financial performance.¶
(5) A service area need will not exist if:¶
(a) The remaining CCOs in the service area are determined to meet the contractual requirements to service the service area's population; or¶
(b) One or more CCOs serving a contiguous area indicate interest to the Authority ~~shall issue a second announcement o~~upon the initial announcement of the withdrawing CCO and are determined to meet the contractual requirements to service the service area's population.¶
(6) If the Authority~~'s identification of a need for a SAC and when LOIAs are~~ determines that a service area need exists:¶
(a) The Authority shall notify all existing CCOs that the SAC process is being initiated and that the Authority will begin accepting LOIAs. The announcement shall specify when the LOIA is due;¶
(~~c~~b) CCOs that want to be considered for ~~a SAC~~expansion into the service area shall submit their LOIAs by the deadline indicated in the Authority's notice of ~~a need for a SAC~~the SAC process being initiated. CCOs shall designate a sole point of contact in their LOIA for this process. The Authority will not accept an LOIA or any subsequent SAC application materials from a CCO that has not submitted an LOIA by the deadline indicated in the Authority's notice;¶
(~~d~~c) The Authority shall send a letter of acknowledgement to the CCO within ~~10~~five (5) calendar days of receipt of the LOIA.¶
(~~5~~7) Within 30 calendar days of the date specified by the Authority as the due date for submission of an LOIA, the CCO shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC ~~application~~ packet. CCOs can locate a SAC packet on the CCO Contract Forms page.¶
(~~6~~8) CCOs applying ~~for the service area change~~through the SAC process outlined in this rule must meet the requirements set forth in ORS 414.572 and submit documentation as it applies to the new service area~~s~~ indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3700 and 410-141-3705, shall be included in the acknowledgement letter sent by the Authority as described in section ~~4(d~~6(c) of this rule, which shall include, but is not limited to, information related to the following:¶
(a) Delivery system network and provider capacity reports highlighting any providers operating in the new service area or existing contracted providers expanding their services into the new service area~~. This report would include providers of physical health, dental services , behavioral health, and non-emergent medical transportation. New relationships with Non-Emergent Medical Transportation brokerages are to be included;¶~~
~~(b) Updated financial reports;¶~~
~~(c) Updated CCO governance organizational charts reflecting any changes due to new service area including CCO leadership and managerial staffing, changes to Community Advisory Committee members, Clinical Advisory Panels membership, and any other committee or governance structure change as a result of operating in the new service area;¶~~
~~(d) Letters of community support from the community or communities in the new service area in which the CCO is applying to operate;¶~~
~~(e) List of specific new zip codes the CCO intends to serve and the estimated enrollment for each zip code area;~~¶
(b) Any updates to the most recently submitted quarterly financial report;¶
(~~f~~c) ~~Memorandums of understanding or letters of intent to enter into memorandums of understanding with local APD/AAA agencies, local mental health authority, local public health authority, and any other key stakeholders represented in the new service area;¶~~
~~(g) Updated Community Health Improvement Plan (CHP) reflecting new service area goals, if applicable;¶~~

~~(h) Updated Transformation Plan benchmarks or focus areas reflecting new service area goals, if applicable~~An updated subcontractor report;¶
(~~i~~d) Information related to how services in the new service area will impact existing operations, including updated policies and procedures, as applicable;¶
(~~j~~e) Information related to identifying regional, cultural, socioeconomic, and racial disparities in health care that exist among the enrollees in the new service area and establishing community support for those areas of need; and¶
(~~k~~f) Information related to coordination of care and transfer of new members, specifically high-risk members or members with special health care needs.¶
(~~7~~9) The Authority shall review SAC packets from all CCOs that have timely submitted an LOIA and SAC packet as required by this rule and that are considered responsive and completed as set forth in this rule.¶
(~~8~~a) During its review of the SAC packets, the Authority may request additional information from a CCO. If additional information is requested, the CCO shall submit the additional information to the Authority within ~~30~~14 days of the request.¶
(~~9~~b) Within ~~6~~30 calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information.¶
(c) To be eligible for recertification in the new service area, the applicant must meet standards established by the Authority~~;~~ and this rule, and be in compliance with the contract between the CCO and the Authority.¶
(10) The Authority shall determine which CCO(s) will be selected to serve the new service area under the procedures and criteria set forth in OAR 410-141-3700(4) and 410-141-3705.¶
(11) The Authority shall prepare a contract amendment for document review and signature ~~to~~for each CCO that receives approval to expand into the new service area. The CCO shall have ~~6~~30 calendar days to return an executed contract amendment for the service area change.¶
(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3550.
Statutory/Other Authority: ORS 413.042, 414.625, 414.645
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-3835

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: 1) Clarify the expectation of attempts for additional information for prescription drug prior authorizations (PAs), 2) Clarify what notifications need to be sent and when for PAs not involving prescription drugs, and 3) Replace MCE (managed care entity) with CCO (coordinated care organization) throughout.

CHANGES TO RULE:

410-141-3835
~~MCE~~CCO Service Authorization
(1) Coverage of services is outlined by ~~MCE~~CCO contract and Oregon Health Plan (OHP) benefits coverage in OAR 410-120-1210 and OAR 410-120-1160.¶
(2) A member may access urgent and emergency services 24 hours a day, seven (7) days a week without prior authorization.¶
(3) The ~~MCE may~~CCO must not require a member to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. A member may self-refer to assessment, evaluation, and behavioral health services from the Provider Network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.¶
(4) A member may access the following outpatient ~~behavioral health~~ services from within the ~~MCE~~CCO's Provider Network, without Prior Authorization, including but not limited to:¶
(a) "Assertive Community Treatment" as defined in OAR 309-019-0105, "Enhanced Care Services" as defined in OAR 309-019-0105, "Enhanced Care Outreach Services" as defined in OAR 309-019-0105, "Wraparound" as defined in OAR 309-019-0105, "Behavior Supports, Crisis Care" as defined in OAR 309-019-0105, "Respite Care" as defined in OAR 309-019-0105, and "Intensive Outpatient Services and Supports" as defined in OAR 309-019-01~~6~~05;¶
(b) Behavioral Health Peer Delivered Services as defined in OAR 309-019-0125 from within the ~~MCE~~CCO's Provider Network;¶
(c) Medication-Assisted Treatment for Substance Use Disorders as defined in OAR 309-019-0105, including opioid and opiate use disorders. Prior authorization may only be required:¶
(A) For a medication approved by the United States Food and Drug Administration after January 1, 2024; or¶
(B) For a brand name drug for medication-assisted treatment if a generic equivalent is available to substitute for the prescribed brand name drug. For the purposes of this rule, a different formulation of the medication is not a generic equivalent.¶
(d) Drugs prescribed for the prevention or treatment of human immunodeficiency virus (HIV):¶
(A) When the drug has been approved by the United States Food and Drug Administration for the prevention or treatment of HIV and determined to be medically necessary by the prescribing provider;¶
(B) Step therapy must also not be required for these drugs.¶
(5) Contractors must permit out-of-network IHCPs to refer a~~n MCE~~ CCO-enrolled American Indian/Alaska Native to a network provider for covered services as required by 42 CFR 438.14(b)(6).¶
(6) The ~~MCE~~CCO shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-3830.¶
(7) ~~MCEs may~~CCOs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.¶
(8) ~~MCE~~CCOs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. ~~MCE~~CCOs shall observe required timely access to service timelines as indicated in OAR 410-141-3515.¶
(9) ~~MCE~~CCOs may place appropriate limits on a service authorization for Covered Services based on Medical Necessity and Medical Appropriateness as defined in OAR 410-120-0000, or for utilization control provided that the ~~MCE~~CCO:¶
(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;¶
(b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;¶

(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20 and the member's free choice of provider consistent with 42 USC § 1396a(a)(23)(B) and 42 CFR § 431.51; and¶
(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.¶
(10) ~~MCEs may~~CCOs must not use quality of life in general measures in establishing utilization controls (e.g., prior authorization) or otherwise making benefit determinations per OAR 410-120-1320.¶
(11) Once a member is determined to be eligible for health-related social needs (HRSN) Services as outlined in OAR 410-120-2000, OAR 410-120-2005, and OAR 410-120-2015, ~~MCE~~CCOs may place appropriate limits on a service authorization for HRSN Services or for utilization control provided the ~~MCE~~CCO:¶
(a) Ensures the HRSN Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; ~~and~~¶
(b) Authorizes the HRSN Services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports; and¶
(c) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue the delivery of HRSN Services to any member who is eligible for those services under OAR 410-120-2000, OAR 410-120-2005, and OAR 410-120-2015.¶
(12) For authorization of services:¶
(a) Each ~~MCE~~CCO shall follow the following timeframes for authorization requests other than for drug or HRSN services:¶
(A) For standard authorization requests for services not previously authorized and not for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice per paragraph (G) in this section as expeditiously as the member's condition requires and no later than seven (7) calendar days following receipt of the request for service. ~~An extension of up to fourte~~¶
(B) For expedited authorization decisions, provide notice per paragraph (G) in this section as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;¶
(C) If additional documentation is required to render a decision for requests in paragraphs (A) and (B), make one (1) attempt to obtain the information during the seven (~~14) additional days~~7) calendar day standard review period or 72 hour expedited review period. ¶
(D) An extension of up to 14 calendar days for a standard or expedited authorization decision in paragraph (A) or (B) is possible if the following applies:¶
(i) The member, the member's representative, or provider requests an extension; or¶
(ii) The ~~MCE~~CCO needs additional information to process the request, and the extension is in the member's interest. If the Authority requests, the ~~MCE~~CCO will justify a need for the additional information and how the extension is in the member's interest.¶
(~~B~~E) ~~For expedited authorization deci~~If a 14 calendar day extension has been justified, the CCO shall:¶
(i) Give written notice to the member of the reason for the extension~~s:~~;¶
(i~~) The MCE shall provide notice~~ii) Respond to the request for authorization per paragraph (G) in this section as expeditiously as the member's health or mental health condition requires ~~and~~, but no later than ~~72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;¶~~
~~(ii) The MCE may extend the 72 hour period up to fourteen (14) days if the member requests an extension or if the MCE justifies to the Authority upon request a need for addition~~the expiration of the extension; and¶
(iii) If the reason for the extension is to obtain additional documentation, make two (2) attempts to obtain the information during the extended review period in addition to the attempt required in paragraph (C) for the initial review period. The total of three (3) attempts shall in~~formation and how the extension is in the member's interest~~clude the use of two (2) methods to obtain the information.¶
(~~C~~F) For all prior authorization requests for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice per paragraph (G) in this section as expeditiously as the member's condition requires and no later than 72 hours following receipt of the request for service. No extension shall be allowed.¶
(G) Responses to requests for prior authorization of services in paragraphs (A), (B), (E) and (F) in this section shall be in one of the following forms:¶
(i) A written, electronic or telephonic notice of the approval of the service as requested to the requesting provider; or¶
(ii) A written notice of adverse benefit determination per OAR 410-141-3885 to the requesting provider, the

member and the member's representative.¶
(b) Prior authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the ~~MCE~~CCOs as follows:¶
(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5) of the Social Security Act. This shall include one attempt within the first 24 hours to obtain additional necessary information if needed. An initial response shall include:¶
(i) A written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing practitioner, and when known to the ~~MCE~~CCO, the pharmacy; or¶
(ii) A written notice of adverse benefit determination of the drug per OAR 410-141-3885 to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the ~~MCE~~CCO, the pharmacy if the drug is denied or partially approved; or¶
(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the ~~MCE~~CCO's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or¶
(iv) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request ~~shall~~must not delay a decision to approve or deny the drug within 72 hours.¶
(B) The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug;¶
(C) If the response is a request for additional documentation, the ~~MCE~~CCO shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:¶
(i) Upon receiving the ~~MCE~~CCO's completed prior authorization forms and required documentation, the ~~MCE~~CCO shall issue a decision as expeditiously as the member's health requires, but no later than 72 hours from the date and time stamp of the initial request for prior authorization as follows:¶
(I) If the drug is approved as requested, the ~~MCE~~CCO shall notify the member in writing and prescribing practitioner, and when known to the ~~MCE~~CCO, the pharmacy, telephonically, or electronically; or¶
(II) If the drug is denied or partially approved, the ~~MCE~~CCO shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the ~~MCE~~CCO, the pharmacy.¶
(ii) If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the ~~MCE~~CCO shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the ~~MCE~~CCO, the pharmacy.¶
(D) The ~~MCE~~CCO shall provide approved services as expeditiously as the member's health condition requires;¶
(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the ~~MCE~~CCO makes a coverage decision.¶
(c) For HRSN services, the CCO shall comply with the service authorization timelines in OAR 410-120-2020.¶
(d) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each ~~MCE~~CCO shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;¶
(~~d~~e) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;¶
(~~e~~f) ~~MCE~~CCOs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR § 438.404 and OAR 410-141-3885;¶
(~~f~~g) The ~~MCE~~CCO and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:¶
(A) For medical, behavioral, or oral health Covered Services:¶
(i) The ~~MCE~~CCO shall consult with the requesting provider for medical, behavioral, or oral health services when necessary:¶
(I) Requesting all the appropriate information to support decision making as early in the review process as possible; and¶
(II) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.¶
(ii) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical,

behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:¶
(I) Deny a service authorization request;¶
(II) Reduce a previously authorized service request; or¶
(III) Authorize a service in an amount, duration, or scope that is less than requested.¶
(B) For HRSN Services, the ~~MCE~~CCO shall comply with OAR 410-120-2020.¶
(C) ~~MCE~~CCOs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify timeframes for the following:¶
(i) Date and time stamping prior authorization requests when received;¶
(ii) Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid;¶
(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;¶
(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;¶
(v) Providing services after office hours and on weekends that require prior authorization.¶
(D) A~~n MCE~~ CCO shall make a determination on at least 95 percent of valid prior authorization requests within two (2) business days of receipt of a prior authorization or reauthorization request related to:¶
(i) Drugs;¶
(ii) Alcohol;¶
(iii) Drug services; or¶
(iv) Care required while in a skilled nursing facility.¶
~~(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within seven (7) calendar days of receipt of the request as set forth in OAR 410-141-3885 unless otherwise specified in OHP program rules:¶~~
~~(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the seven (7) calendar day period;¶~~
~~(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;¶~~
~~(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.¶~~
(13) Report to the Authority annually requests for prior authorization. The report shall include:¶
(a) The number of requests received;¶
(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;¶
(c) The number of requests that were initially approved; and¶
(d) The number of denials that were reversed by internal appeals or external reviews.
Statutory/Other Authority: ORS 413.042, 414.065, 414.572, 414.591, 414.605
Statutes/Other Implemented: ORS 414.065, 414.570-414.686

AMEND: 410-141-3845

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Require CCOs to provide policies and procedures for Flexible Services to OHA upon request instead of submitting them for OHA approval.

CHANGES TO RULE:

410-141-3845
Flexible Services
(1) The goals of Flexible Services 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. Flexible Services are provided as a complement to covered health care services:¶
(a) Flexible Services may be provided at the member- or community-level, as defined below;¶
(b) CCOs have the flexibility to identify and provide Flexible Services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as they satisfy the requirements of this rule;¶
(c) ~~As allowed under 42 CFR 438.6(c), MCEs may offer additional services that are separate from Flexible Services and delivered at the complete discretion of the CCO;¶~~
~~(d)~~ Flexible Services 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 Flexible Services within the meaning of this rule, a service must meet the following requirements, consistent with 45 CFR § 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 Flexible Services:¶
(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 Flexible Services. These P&Ps shall be submitted ~~to the Authority for approval:~~within five (5) business days of the Authority's request.¶
(a) Flexible Services 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 Flexible Services spending at the community level shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any community-level Flexible Services spending priorities identified by the Authority;¶
(c) The P&Ps shall describe how Flexible Services spending decisions are made, including the role of the CAC and tribes in community-level Flexible Services spending decisions;¶
(d) CCOs ~~shall~~must not limit the range of permissible Flexible Services by any means other than by enforcing the limits defined in this rule.¶
(4) Member-level Flexible Services are cost-effective services offered to an individual member as an adjunct to covered benefits. Member-level 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 Flexible Services needed to supplement the member's care:¶
(a) CCOs shall provide members with a written notification of a refusal of a member-level 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 a member-level Flexible Services 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-level Flexible Services 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 community-level Flexible Services spending decisions.¶
(6) CCOs shall submit their financial reporting for Flexible 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 Flexible Services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-3920

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: 1) Clarify that brokerages and CCOs need to notify members by their preferred method of contact for denials and cancellations, prior to when the service was to occur, 2) Remove requirement that a notice of adverse benefit determination needs to be sent to provider the member was going to see for medical services when non-emergent medical transportation (NEMT) is denied, and 3) Clarify that NEMT does not provide services to non-pre-scheduled services provided in an emergency room or emergency department setting (this includes all levels of transport services).

CHANGES TO RULE:

410-141-3920
Transportation: NEMT General Requirements
(1) For definitions of terms used in 410-141-3920 to 410-141-3965, please see OAR 141-136-3000.¶
(2) A Coordinated Care Organization (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 section (~~1~~2) of this rule unless context dictates otherwise:¶
(a) The CCO is responsible for NEMT services for all of its members' health care services consistent with the covered services described in OAR 410-141-3820 and the excluded services and limitations described in OAR 410-141-3825 and (~~1~~2)(b) and (~~1~~2)(c) of this rule;¶
(b) NEMT services for those health care services that, based on the member's plan type, are paid by the Authority's fee-for-service program and that, based on rule or contract, are carved-out from or otherwise not covered by the CCO and provided by the Authority~~.~~;¶
(c) NEMT must not be provided for HRSN Services;¶
(d) NEMT must not provide transportation services, including public transportation, mileage reimbursement or driver provided rides, to an emergency room or emergency department setting for medical services that are not pre-scheduled, including from urgent care clinics;¶
(e) For members enrolled in the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program, both of which are defined in OAR chapter 410, division 200, the CCO is responsible only for NEMT services related to the member's dental services.¶
(~~2~~3) A CCO shall provide a toll-free call center for members to request rides.¶
(a) The CCO shall ensure that its call center operates, at a minimum, Monday through Friday from 9:00 a.m. to 5:00 p.m. The CCO may close its call center on New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the CCO requests the closure at least thirty (30) days in advance.¶
(b) Consistent with OAR 410-141-3505, a CCO may subcontract the operation of its call center. If the CCO's subcontractor is also contracted by the Authority as an NEMT brokerage for FFS members, the CCO remains fully accountable for the performance of the subcontracted work related to the CCO contract.¶
(~~3~~4) 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~~5) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).¶
(~~5~~6) A CCO shall have written policies and procedures regarding its NEMT services. All policies and procedures must be provided to all Members either in Contractor's Member Handbook or in a stand-alone document referred to as a "NEMT rider guide" that meets the delivery and content specifications as defined by the Authority. The CCO's written policies and procedures regarding NEMT services shall provide, without limitation, for the following:¶
(a) Allow members or their representatives to schedule:¶
(A) NEMT services up to ~~ninety (~~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. Drivers are not permitted to:¶
(A) 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) 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.¶
(c) Describe passenger rights and responsibilities as set forth in 42 CFR §438.210, and as set forth in OARs 410-141-3920 through 410-141-3960, and other state and federal administrative statutes and rules relating to the rights and responsibilities of Medicaid recipients such as the right to file a grievance and request an appeal or reconsideration.¶
(~~6~~7) A CCO or brokerage must review a requested NEMT ride service authorization ~~request with~~in the following m~~odifications:¶~~
~~(a) Approving and scheduling, or denying, a request for NEMT ride services (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for their appointment:¶~~
~~(A) If approved, notify members by their preferred method of contact of the applicable arrangements prior to the date of the NEMT~~anner:¶
(a) When providing notification to the member or member representative of an approval, denial or cancellation of the member's requested ride service it must occur by their preferred method of contact.¶
(A) If approving the NEMT ride service request, notification of the applicable transportation arrangements shall occur prior to the time of the service or no less than 48 hours prior to the time of the service. This timeframe shall be reduced if the request for a ride service occurs close to the scheduled ride service time to ensure the member is informed of the approved requested service;¶
(B) If ~~int~~den~~d~~ying ~~to deny the~~a request for an NEMT ride~~,~~ service the CCO or NEMT brokerage must provide ~~a~~:¶
(i) A secondary review by another employee with knowledge of NEMT service requirements ~~and mail the NOABD within 72 hours of denial determination.¶~~
~~(b) Adhering to the grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 available with respect to NEMT services; and¶~~
~~(c) The CCO shall mail, within 72 hours of denial, a notice of adverse benefit~~, prior to determination of a denial;¶
(ii) Notification to the member or member representative. Notification must occur prior to sending a notice of adverse benefit determination (NOABD) and at least 48 hours prior to the time of the requested ride service. This timeframe shall be reduced if the request for a ride service occurs close to the scheduled ride service time to ensure the member is informed of the denied requested service;¶
(iii) The member with a mailed NOABD within 72 hours of denial determination ~~to:~~;¶
(~~A~~C) ~~A member denied a ride; and¶~~
~~(B) CCOs shall provide a copy of the NOABD to the provider with which the affected member was scheduled for an appointment, when~~If canceling a previously approved NEMT ride service request (e.g., due to adverse weather conditions), the CCO or NEMT brokerage must provide notification to the member or the member's representative prior to the time that the ~~provider is part of the CCO's provider netw~~ride service was to occur or~~k~~ ~~and requested the transportation on the member's behalf, in a format that is agreeable to the provider and provides sufficient documentation of notification~~s soon as practical.¶
(b) Adhering to the grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 available with respect to NEMT services.¶
(~~7~~8) This rule applies only to the Authority's pilot project in effect for 2/16/2024 through 2/15/2025, which allows a CCO to utilize a Transportation Network Company (TNC) to provide NEMT services to the CCO's members.¶
(a) Transportation network company (TNC) has the meaning found in ORS 742.520.¶
(b) A TNC must obtain a certification from the Oregon Health Authority to participate in the TNC Pilot Program as an NEMT provider. Certification for the TNC pilot program is obtained by submitting to HSD.QualityAssurance@odhsoha.oregon.gov the following documents:¶
(A) A document that identifies the process or policies the TNC follows and documents its compliance with the requirement that each driver has a valid driver license. The TNC must maintain records of their drivers participating in the TNC Pilot and share relevant information with OHA when requested;¶
(B) A document that identifies the processes or policies the TNC follows and documents its compliance with the processes and policies, to ensure that proposed TNC pilot program drivers, employees, agents and contractors are not, as described in 42 CFR §438.610 (a) or (b): Excluded, suspended, or debarred, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulations or federal Executive Order No. 12549 or the implementation guidelines for federal Executive Order No. 12549; or Excluded from participation in any federal health care program under section 1128 or 1128A of the Social Security Act as described in 42 CFR 438.610;¶
(C) A document that identifies the process or policies that the TNC follows and documents its compliance with the processes and policies, to ensure that all TNC proposed pilot program drivers have not: ~~C~~committed more than three (3) traffic violations under ORS 801.557 in the past three (3) years; or ~~C~~committed one (1) or more traffic crimes under ORS 801.545 within the past seven (7) years; or ~~H~~have been convicted of Driving Under the Influence

of Intoxicants under ORS 813.010 within the last seven (7) years;¶
(D) The TNC's policy for monitoring the driving records and criminal records of all of its proposed TNC pilot program drivers, employees, agents, and contractors;¶
(E) The TNC's policy for compliance with federal and state regulatory requirements to ensure all OHP member information is protected in accordance with OAR 410-136-3280;¶
(F) Proof of insurance and policy compliant with ORS 742.520(1)(b).¶
(c) Upon receipt of the documents identified in subsection (b) of this rule, the application shall be reviewed and if all requirements are met, then the Authority shall issue a certificate of approval to participate in the TNC Pilot Program.¶
(A) Once certification is issued, a TNC certified to participate in the TNC Pilot Program shall be eligible to provide rides to OHP Members upon request from the Authority or a CCO;¶
(B) Rides authorized to be provided by a driver employed by or contracted with a certified TNC Pilot Program may only be utilized by a CCO or the Authority if:¶
(i) No NEMT driver who meets the requirements identified in OAR 410-136-3040 (NEMT Driver) accepts an NEMT brokerage request within ~~twenty-four (~~24~~)~~ hours of the scheduled ride time; or¶
(ii) A previously scheduled NEMT Driver cancels the assigned ride within ~~twenty-four (~~24~~)~~ hours of the scheduled ride time and no other NEMT Driver accepts, within a reasonable period of time, the brokerage's new request for another NEMT Driver; or¶
(iii) The previously scheduled NEMT Driver does not arrive at the pick-up location within ~~fifteen (~~15~~)~~ minutes after the scheduled pick-up time.
Statutory/Other Authority: ORS 413.042, ORS 414.625
Statutes/Other Implemented: ORS 414.625, 414.572, 414.605, 414.665, 414.719

AMEND: 410-141-3935

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Clarify that it does not need to be the same attendant traveling to and from appointment for a minor or person(s) with special needs.

CHANGES TO RULE:

410-141-3935
Transportation: Attendants for Child and Special Needs Transports
(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 th~~For members who are 12 years or younger or members who have additional needs, an adult attendant must be pre~~turn~~sent for all trips.~~-~~¶
(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 m~~ay~~ust 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

AMEND: 410-141-3955

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: Clarify that members shall be notified of a service modification when the need is determined and that the brokerage must make three reasonable attempts at providing the notification.

CHANGES TO RULE:

410-141-3955
Transportation: Member Service Modifications and Rights
(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 m~~ay~~ust 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;¶
(f) Exhibits chronic lateness, defined as being more than 15 minutes late after the driver arrives (within the pickup window) for 25 percent or more of those trips occurring within the previous three-months; or¶
(g) 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 ~~p~~bro~~vide~~kerage/subcontractor 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~~When the NEMT brokerage determines a need for a service modification, they shall notify the member using the member's preferred method of notification. NEMT brokerages must make three (3) separate reasonable attempts to notify the member. This shall be followed by written confirmation to the member, the member's care coordinator, and any requesting provider. Before modifying services, the NEMT ~~p~~bro~~vide~~kerage/subcontractor, 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 m~~ay~~ust 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 m~~ay~~ust 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, 414.572
Statutes/Other Implemented: ORS 414.572

AMEND: 410-141-3960

NOTICE FILED DATE: 04/30/2026

RULE SUMMARY: 1) Expand on what classifies as part of 4 hours of travel time (e.g., does not include time at or waiting for appointment to begin), 2) A CCO shall disallow a client whose reimbursement verification is received more than 45 days after the date of travel, 3) Clarify documentation that is needed to receive reimbursement for mileage, meals and lodging, and 4) Clarification that if a member submits a reimbursement verification form that is incomplete that the subcontractor and CCO should not deny reimbursement, but instead take up to 14 additional calendar days to help the member submit a completed form. However, if a form is submitted after 45 days from the date of transport that is not considered incomplete, but instead is considered a denial.

CHANGES TO RULE:

410-141-3960
Transportation: Member Reimbursed Mileage, Meals, and Lodging
(1) A Coordinated Care Organization (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~~shall 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 Oregon Health ~~Plan (OHP) fee schedule is available on the Oregon Health Authorities (~~Authority's reimbursement rates are available by published memo on the Medical Transportation Services Program section of the Authority's~~)~~ website.¶
(4) The member must return any documentation a CCO requires before receiving reimbursement. Documentation may include, but is not limited to:¶
(a) Receipts;¶
(b) Lodging invoices;¶
(c) Flight information;¶
(d) An appointment verification form.¶
(5) A member must be reimbursed within ~~fourteen (~~14~~)~~ days after verifying the member's attendance of the appointment or after the CCO receiv~~inges~~ the reimbursement request form, if required.¶
(a) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10;~~ or~~¶
(b) ~~A CCO mu~~If the member reimbursement request is su~~e the member a Notice of Adverse Benefit Determination, in accordance with requirements in OAR 410-141-3885, within fourteen (14) days if the member reimbursement is denied for any reason. If the member reimbursement request is incomplete the CCO shall take an additional fourteen (14) days to assist the member in completing the submission~~bmitted before 45 days from the date of transport, but is incomplete, the CCO shall take up to an additional 14 calendar days to assist the member in completing the submission. Denial must not take place while the CCO is assisting a member with an incomplete request;¶
(c) A CCO must issue the member a Notice of Adverse Benefit Determination, in accordance with requirements in OAR 410-141-3885, within 14 calendar days of the denial of a member reimbursement.¶
(6) A CCO shall reimburse members for meals when a member travels:¶
(a) For a minimum of four (4) hours round-trip; and¶
(b) The travel time must span the following meal times:¶
(A) For a breakfast allowance, the travel must begin before 6:00 a.m.;¶
(B) For a lunch allowance, the travel must span the entire period from 11:30 a.m. through 1:30 p.m.; and¶
(C) For a dinner allowance, the travel must end after 6:30 p.m.¶
(D) Travel time is considered to be time spent traveling to or from an appointment, it does not include time spent in or waiting for the appointment.¶
(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 5:00 a.m. in order to reach a scheduled appointment; or¶
(b) Travel from a scheduled appointment would end after 9:00 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
Statutes/Other Implemented: ORS 413.042