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

FILING CAPTION: Semi-Annual CCO Rule Updates & New Interoperability Rule

EFFECTIVE DATE: 07/01/2021

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RULES:
410-141-3500, 410-141-3510, 410-141-3585, 410-141-3591, 410-141-3805, 410-141-3810, 410-141-3860, 410-141-3875, 410-141-3885, 410-141-3890, 410-141-3895, 410-141-3905, 410-141-3915

AMEND: 410-141-3500

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR chapter 410, division 141. The Authority also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule. ¶
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. ¶
(3) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000. ¶
(4) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000. ¶
(5) "The Authority" means the Oregon Health Authority. ¶
(6) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other

disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats. ¶
(7) "Auxiliary Aids and Services" means services available to members as defined in 45 CFR Part 92. ¶
(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders. ¶
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect. ¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day. ¶
(11) "Capitated Services" means those covered services that an MCE agrees to provide for a capitation payment under contract with the Authority. ¶
(12) "Capitation Payment" means monthly prepayment to an MCE for capitated services to MCE members. ¶
(13) "Care Plan" means a documented plan that addresses the supportive, therapeutic, cultural, and linguistic health of a member. The member's care plan shall be developed for in collaboration with the Member and the Member's family or representative, and, if applicable, the Member's caregiver so that it incorporates their preferences and goals to ensure engagement and satisfaction. Care plans include, without limitation: ¶
(a) prioritized goals for a member's health; ¶
(b) identifying interventions and resources that will benefit and support the member's goals such as peer support, non-traditional services, community services, employment and housing support; ¶
(c) medication management; and ¶
(d) monitoring and re-evaluation. ¶
(14) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget. ¶
(15) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor. ¶
(16) "Client" means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE member. ¶
(17) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625. CCOs shall afford an opportunity for tribal participation on CACs as follows: ¶
(a) In CCO service areas where only one federally recognized tribe exists, the tribe shall appoint one tribal representative to serve on the CAC; ¶
(b) In CCO service areas where multiple federally recognized tribes exist, each tribe shall appoint a tribal representative to serve on the CAC to ensure full representation of all tribes within the service area; ¶
(c) In metropolitan CCO service areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC. ¶
(18) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality. ¶
(19) "Contract" means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members. ¶
(20) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members. ¶
(21) "Coordinated Care Services" mean an MCE's fully integrated physical health, behavioral health services, and oral health services. ¶
(22) "Corrective Action" or "Corrective Action Plan" means an Authority-initiated request for an MCE or an MCE-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance. ¶
(23) "Dental Care Organization (DCO)" means a prepaid managed care health services organization that

contracts, on a capitated basis, with the Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients. Dental Care Organization also meets the definition of a Prepaid Ambulatory Health Plan as defined under 42 CFR 438.2.¶
(24) "The Department" means the Department of Human Services. ¶
(25) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department. ¶
(26) "Disenrollment" means the act of removing a member from enrollment with an MCE. ¶
(27) "Diversity of the Workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care. ¶
(28) "Enrollment" means the assignment of a member to an MCE for management and coordination of health services. ¶
(29) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include: ¶
(a) Annual exams; ¶
(b) Contraceptive education and counseling to address reproductive health issues; ¶
(c) Prescription contraceptives (such as birth control pills, patches or rings); ¶
(d) IUDs and implantable contraceptives and the procedures requires to insert and remove them; ¶
(e) Injectable hormonal contraceptives (such as Depo-Provera); ¶
(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams); ¶
(g) Laboratory tests including appropriate infectious disease and cancer screening; ¶
(h) Radiology services; ¶
(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions. ¶
(30) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits. ¶
(31) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services. ¶
(32) "Grievance System" means the overall system that includes: ¶
(a) Grievances to an MCE on matters other than adverse benefit determinations; ¶
(b) Appeals to an MCE on adverse benefit determinations; and ¶
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute. ¶
(33) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness. ¶
(34) "Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives. ¶
(35) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP. ¶
(36) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, such as the practices of naturopathy or

chiropractic and often involving nutritional measures. ¶
(37) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency. ¶
(38) "Indian" and/or "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a). ¶
(39) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). ¶
(40) "In Lieu of Service" (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).¶
(41) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English. ¶
(~~41~~2) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. ¶
(~~42~~3) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination. ¶
(~~43~~4) "Legal Holiday" means the days described in ORS 187.010 and 187.020. ¶
(~~44~~5) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor. ¶
(~~45~~6) "Managed Care Entity (MCE)" means, an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(~~46~~7) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), or Physician Care Organization (PCO).¶
(~~47~~8) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both: ¶
(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals; ¶
(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services. ¶
(~~48~~9) "Member" means an OHP client enrolled with an MCE. ¶
(~~49~~50) "Member Representative" means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves. ¶
(5~~0~~1) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. ¶

(5~~1~~2) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers. ¶
(5~~2~~3) "Ombudsperson Services" means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided. ¶
(5~~3~~4) "Oral Health" means conditions of the mouth, teeth, and gums. ¶
(54~~5~~) "Oregon Health Plan (OHP)" means Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both. ¶
(5~~5~~6) "Oregon Integrated and Coordinated Health Care Delivery System" means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.620. ¶
(5~~6~~7) "Participating Provider" means a provider that has a contractual relationship with an MCE and is on their panel of providers. ¶
(5~~7~~8) "Participating Provider Organization" means a group practice, facility, or organization that has a contractual relationship with an MCE and is on the MCE's panel and; ¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or ¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or ¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; ¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization; and ¶
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. ¶
(5~~8~~9) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends. ¶
(~~59~~60) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE. ¶
(6~~0~~1) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include: ¶
(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care; ¶
(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000. ¶
(6~~1~~2) "Provider" means, pursuant to OAR 410-120-0000, an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified. ¶
(6~~2~~3) "Provider Organization" means a group practice, facility, or organization that is: ¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or ¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or ¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; ¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization; and ¶

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. ¶
(6~~3~~4) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. ¶
(6~~4~~5) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services. ¶
(6~~5~~6) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria: ¶
(a) A child or youth, between the ages of birth to 21 years of age; and ¶
(b) Must meet criteria for diagnosis, functional impairment and duration: ¶
(A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder): ¶
(i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions); ¶
(ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder). ¶
(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care; ¶
(C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year. ¶
(6~~6~~7) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either:¶
(a) Have functional disabilities;¶
(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or ¶
(c) Are a Member of the Prioritized Populations as defined in 410-141-3870.¶
(6~~7~~8) "Subcontract" means either: ¶
(a) A contract between an MCE and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the MCE under its contract with the State, or ¶
(b) Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.¶
(6~~8~~9) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State.¶
(~~69~~70) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-

traumatization of the individuals being served within their respective entities. ¶
(7~~0~~1) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area. ¶
(7~~1~~2) "Trauma-informed services" means those services provided using a Trauma Informed Approach. ¶
(7~~2~~3) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative. ¶
(7~~3~~4) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25. ¶
(74~~5~~) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~ORS 414.065
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727

AMEND: 410-141-3510

REPEAL: Temporary 410-141-3510 from DMAP 10-2021

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3510
Provider Contracting and Credentialing
(1) MCEs shall develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards:¶
(a) MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;¶
(b) MCEs shall screen their participating providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes~~;~~, except in the following circumstances for credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the Authority's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.¶
(A) CCOs may rely upon the most recent weekly update of the Authority's active file of vaccine administration providers to meet contractual and regulatory requirements for credentialing COVID-19 vaccine administration providers.¶
(B) CCOs may enroll COVID-19 vaccine administration providers who are included in the Authority's most recent active file of vaccine administration providers.¶
(C) CCOs shall monitor changes in the Authority's weekly active file of vaccine administration providers for terminations and changes.¶
(c) MCEs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, MCEs shall:¶
(A) Ensure that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;¶
(B) Provide training for MCE staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the MCEs administrative policies.¶
(d) The MCE shall provide accurate and timely information to the Authority about:¶
(A) License or certification expiration and renewal dates;¶
(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;¶
(C) If an MCE knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo

contendre").¶
(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.¶
(e) MCEs may not refer members to or use providers that:¶
(A) Have been terminated from Medicaid;¶
(B) Have been excluded as a Medicaid provider by another state;¶
(C) Have been excluded as Medicare/Medicaid providers by CMS; or¶
(D) Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.¶
(f) MCEs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. MCEs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;¶
(g) MCEs shall require each atypical provider to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. MCEs shall require each qualified provider to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);¶
(h) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.¶
(2) An MCE may not discriminate with respect to participation in the MCE against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If an MCE declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:¶
(a) Require that an MCE contract with any health care provider willing to abide by the terms and conditions for participation established by the MCE; or¶
(b) Preclude the MCE from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:¶
(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or¶
(B) Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.¶
(c) The requirements in subsection (b) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.¶
(3) An MCE shall establish an internal review process for a provider aggrieved by a decision under section (4) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.¶
(4) To resolve appeals made to the Authority under sections (3) and (4) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the MCE to participate in the administrative

review. In making a determination of whether there has been discrimination, the Authority shall consider the MCE's:¶
(a) Network adequacy;¶
(b) Provider types and qualifications;¶
(c) Provider disciplines; and¶
(d) Provider reimbursement rates.¶
(5) A prevailing party in an appeal under sections (3) through (4) of this rule shall be awarded the costs of the appeal.¶
(6) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.¶
(7) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.¶
(8) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~ORS 414.065
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727

AMEND: 410-141-3585

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3585
MCE Member Relations: Education and Information
(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE 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) MCEs 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. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats. ¶~~
~~(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. 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 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs 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) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall: ¶~~
~~(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access intensive care coordination (ICC) Services, and where applicable for full benefit dual eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits; ¶~~
~~(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10; ¶~~
~~(c) Inform all members of the availability of Ombudsperson services. ¶~~
~~(5) Written member education materials shall comply with the following language and access requirements: ¶~~
~~(a) Materials shall be translated or include taglines in the prevalent non-English languages in the state as well as 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'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's process for providing alternative formats and auxiliary aids to members may 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 MCE 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, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE 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 shall provide it upon request within five business days. ¶

(6) MCE provider directories 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) Whether the provider will accept new members; ¶

(g) Whether the provider offers both telehealth and in-person appointments;¶

(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an OHA-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office; ¶

(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶

(j) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in 410-141-3735 whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing); ¶

(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment. ¶

(L) The information for each of the following provider types covered under the contract, as applicable to the MCE contract: ¶

(A) Physicians, including specialists; ¶

(B) Hospitals; ¶

(C) Pharmacies; ¶

(D) Behavioral health providers; including specifying substance use treatment providers; ¶

(E) Dental providers. ¶

(m) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format. ¶

(7) Each MCE 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 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies. ¶

(9) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days. ¶

(10) MCEs must notify enrollees: ¶
(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and ¶
(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) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following: ¶
(a) Revision date; ¶
(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in alternate formats; ¶
(c) MCE's office location, mailing address, web address, office hours, and telephone numbers including TTY; ¶
(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the MCE's policy on changing PCPs; ¶
(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers; ¶
(f) Which participating or non-participating provider services the member may self-refer; ¶
(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral; ¶
(h) Explanation of ICC services and how eligible members may access those services; ¶
(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits; ¶
(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home; ¶
(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies; ¶
(L) Information on contracted hospitals in the member's service area; ¶
(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition; ¶
(n) Information on the MCE's grievance and appeals processes and the Authority's contested case hearing procedures, including: ¶
(A) Information about assistance in filling out forms and completing the grievance process available from the MCE to the member as outlined in OAR 410-141-3875; ¶
(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3885. ¶
(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsperson; ¶
(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCE network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries; ¶
(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries; ¶

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees; ¶
(s) Information on advance directive policies including: ¶
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; ¶
(B) The MCE's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience. ¶
(t) Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives; ¶
(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected; ¶
(v) How and when members are to obtain ambulance services; ¶
(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services; ¶
(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled; ¶
(y) How to access in-network retail and mail-order pharmacies; ¶
(z) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs; ¶
(aa) The MCE's confidentiality policy; ¶
(bb) How and where members may access any benefits that are available under OHP but are not covered under the MCE's contract, including any cost sharing; ¶
(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs; ¶
(dd) MCEs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members; ¶
(ee) The "Oregon Health Plan Client Handbook" is in addition to the MCE's member handbook, and an MCE may not use it to substitute for any component of the MCE's member handbook. ¶
(12) 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 providers or other individuals or programs approved by the MCE may provide health education. MCEs 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 may 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) MCEs 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 ICC services and how eligible members may access those services. MCEs should ensure that ICC-related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS; ¶

~~(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) MCEs shall provide written notice to affected members of any significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days. ¶~~
~~(13~~¶
(a) Is intended solely for members; and¶
(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.¶
(2) MCEs 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. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.¶
(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. 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. MCEs 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) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:¶
(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access intensive care coordination (ICC) Services, and where applicable for full benefit dual eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;¶
(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305 and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10;¶
(c) 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 tagline 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'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's process for providing alternative formats and auxiliary aids to members may 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 MCE 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, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE 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 shall provide it upon request within five business days.¶
(6) MCE provider directories 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) Whether the provider will accept new members;¶
(g) Whether the provider offers both telehealth and in-person appointments;¶
(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an OHA-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;¶
(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶
(j) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in OAR 410-141-3735 whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);¶
(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment.¶
(L) The information for each of the following provider types covered under the contract, as applicable to the MCE contract:¶
(A) Physicians, including specialists;¶
(B) Hospitals;¶
(C) Pharmacies;¶
(D) Behavioral health providers; including specifying substance use treatment providers;¶
(E) Dental providers.¶
(m) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format.¶
(7) Each MCE 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 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.¶
(9) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.¶
(10) MCEs must notify enrollees:¶
(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages as defined in OAR 410-141-3575 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and¶
(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) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory.¶
(12) The CCO member handbook shall be written in plain language using a font size no smaller than 12 point. At a minimum, the member handbook shall contain the following:¶
(a) Revision date including month, day, and year;¶
(b) Tag lines in English and other prevalent non-English languages, as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18 point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:¶
(A) How members may, at no cost to them, access sign language and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;¶
(B) The toll-free and TTY/TDY telephone numbers of the MCE's customer service unit.¶
(c) CCO's office location, mailing address, web address, office hours, and telephone numbers including TTY; ¶
(d) Explanation of access and care standards consistent with the requirements set forth in 42 CFR 438.206 and OARs 410-141-3515 and 410-141-3860;¶
(e) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the CCO's policy on changing PCPs;¶
(f) Explanation of the health risk screening process;¶
(g) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;¶
(h) Explanation that American Indian and Alaskan Native members of the CCO may receive care from a tribal wellness center, Indian Health Services clinic, or the Native American Rehabilitation Association of the Northwest (NARA);¶
(i) Explanation of which participating or non-participating provider services the member may self-refer;¶
(j) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;¶
(k) Information on how to obtain a second opinion;¶
(L) Explanation of ICC services, including persons eligible as priority populations served and requirements for Intensive Care Coordination care planning, and how eligible members may access those services;¶
(m) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;¶
(n) Explanation of care coordination services and how the member can request and access a care coordinator.¶
(o) Information about the benefits and availability of traditional health worker (THW) services as defined in OAR 410-180-0305, and how to contact the CCO's THW liaison.¶
(p) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;¶
(q) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies and use of 911;¶
(r) Information on how to contact the CCO's in-house or subcontracted after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long term care provider or facility.¶
(s) Information on contracted hospitals in the member's service area including hospital name, physical address, toll-free phone number, TTY, and webpage;¶
(t) Information on mobile crisis services and crisis hotline for members, including information that crisis response services are available 24 hours a day for members receiving Intensive In-Home Behavioral Health Treatment.¶
(u) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;¶
(v) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to,

the information contained in sections (4) and (5) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services.¶
(w) A statement or narrative that articulates the CCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;¶
(x) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;¶
(y) Information on the CCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:¶
(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3875;¶
(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;¶
(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.¶
(z) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;¶
(z) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;¶
(aa) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;¶
(bb) Information on coverage and billing for out of state services, including information how to access additional assistance from the CCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;¶
(cc) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including how to access such services and specific communications for members who are becoming new Medicare enrollees; ¶
(dd) Information on advance directive policies including:¶
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;¶
(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;¶
(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with OHA, and information on how to file such a complaint with OHA;¶
(ee) Whether or not the CCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;¶
(ff) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;¶
(gg) How and when members are to obtain ambulance services;¶
(hh) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;¶
(ii) All NEMT policies and procedures as outlined in OAR 410-141-3920 through 410-141-3965 and the CCO Contract, unless the member is provided with a stand-alone document, referred to as a "NEMT Rider Guide";¶
(jj) Explanation of the covered and non-covered services in sufficient detail to ensure that members understand the benefits to which they are entitled, including but not limited to; ¶
(A) A delineation of the non-covered services the CCO coordinates from the non-covered services the CCO does not coordinate;¶

(B) Contact information for the Authority contractor responsible for coordination of non-covered services the CCO is not obligated to coordinate;¶
(C) Explanation that the CCO is responsible to arrange transportation for non-covered services that are coordinated by the CCO.¶
(kk) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the CCO and how to contact Oregon Health Authority for information regarding accessing the service;¶
(LL) How to access in-network retail and mail-order pharmacies;¶
(mm) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;¶
(nn) The CCO's confidentiality policy;¶
(oo) Explanation of the CCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly;¶
(pp) How and where members may access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;¶
(qq) When and how members may voluntarily and involuntarily disenroll from CCOs and change CCOs;¶
(rr) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including CCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the CCO's written transition of care policy;¶
(ss) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;¶
(tt) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and an CCO may not use it to substitute for any component of the CCO's member handbook.¶
(13) The DCO member handbook shall be written in plain language using a font size no smaller than 12 point. The DCO member handbook is required for DCOs directly contracted by OHA. At a minimum, the member handbook shall contain the following:¶
(a) The revision date, including month, day, and year;¶
(b) Tag lines in English and other prevalent non-English languages, as defined in as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18-point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:¶
(A) How members may access free sign and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;¶
(B) The toll-free and TTY/TDY telephone numbers of the DCO's customer service unit.¶
(c) DCO's office location, mailing address, web address, office hours, and telephone numbers including TTY; ¶
(d) The toll-free number for any partners providing services directly to members, including non-emergency medical transportation providers;¶
(e) The DCO's confidentiality policy;¶
(f) Information about the structure and operations of the DCO, including whether or not the DCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;¶
(g) Explanation of oral health benefits and covered services available to members without charge in sufficient detail to ensure that members understand the benefits to which they are entitled;¶
(h) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including DCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the DCO's written transition of care policy;¶
(i) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a Primary Care Dentist (PCD),

other prescribing provider, or obtain new orders during that period;¶
(j) Explanation of how to choose a PCD, how to make an appointment, how to change PCDs, and the DCO's policy on changing PCDs;¶
(k) Explanation that American Indian/Native Alaskan members may choose an Indian Health Care Provider (IHCP) as the member's PCD if:¶
(A) The IHCP is participating as a PCD within the provider network; and¶
(B) The member is otherwise eligible to receive services from such Indian Health Care Provider; and¶
(C) The IHCP has the capacity to provide the services to such members.¶
(L) Explanation that American Indian members may obtain covered services from non-participating providers and can be referred by an IHCP to a participating provider for covered services in accordance with 42 CFR §438.14;¶
(m) Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;¶
(n) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (4) and (5) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services.¶
(o) Explanation of the health risk screening process;¶
(p) Information about tobacco dependency and cessation services and how to access such services through the DCO;¶
(q) Explanation of non-emergency medical transportation (NEMT) services, including how the DCO coordinates NEMT services for members and how a member accesses NEMT services.¶
(r) Explanation of care coordination services and how the member can request and access a care coordinator, including information that the DCO must coordinate dental services furnished to the member with the services the member receives from other plans and/or from community and social support providers.¶
(s) Policies on referrals, prior authorization and pre-approval requirements and how to request a referral, including but not limited to the following:¶
(A) No prior authorization or referral is necessary for urgent or emergency dental services including dental post-stabilization services;¶
(B) Information on how to access specialty dental care furnished by the DCO;¶
(C) Information on how to access specialty care and other benefits that are not furnished by the DCO;¶
(t) Information on how to obtain a second opinion;¶
(u) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;¶
(v) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the DCO and how to contact Oregon Health Authority for information regarding accessing the service;¶
(w) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;¶
(x) How and when members are to use emergency services, both locally and when away from home, including examples of dental emergencies and use of 911;¶
(y) Information on how to contact the DCO's after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long-term care provider or facility;¶
(z) Explanation that members can access dental services while out of state in an urgent or emergency situation, including information on how to access additional assistance from the DCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;¶
(aa) Information on when and how members may voluntarily and involuntarily disenroll from DCOs or change DCOs;¶
(bb) A statement or narrative that articulates the DCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;¶
(cc) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's

right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;¶
(dd) Information on the DCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:¶
(A) Information about assistance in filling out forms and completing the grievance process available from the DCO to the member as outlined in OAR 410-141-3875;¶
(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885.¶
(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings. ¶
(ee) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;¶
(ff) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;¶
(gg) Explanation of the DCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly, including contact information for the DCO's Non-discrimination coordinator;¶
(hh) Information about the requirement to provide providers and subcontractors with third-party liability information;¶
(ii) Explanation that the DCO will provide written notice to affected members of any significant changes in provider, program, or service sites that affect the member's ability to access care or services from the DCO's participating providers. Such notice shall be translated as appropriate and provided to the member at least 30 days before the effective date of the change, or as soon as possible if the participating provider has not given the DCO sufficient notification to meet the 30-day notice requirement;¶
(jj) Information on advance directive policies including:¶
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;¶
(B) The DCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;¶
(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with OHA, and information on how to file such a complaint with OHA;¶
(kk) DCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the DCO's internal changes. If changes affect the member's ability to use services or benefits, the DCO shall offer the updated member handbook to all members;¶
(LL) The "Oregon Health Plan Client Handbook" is in addition to the DCO's member handbook, and an DCO may not use it to substitute for any component of the DCO's member handbook.¶
(14) 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 providers or other individuals or programs approved by the MCE may provide health education. MCEs 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 may 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) MCEs 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 ICC services and how eligible members may access those services. MCEs should ensure that ICC-related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;¶
(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) MCEs shall provide written notice to affected members of any significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.¶
(15) MCEs 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, members, and providers.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~ORS 414.065
Statutes/Other Implemented: ORS 414.~~610 –~~065, 414.~~685~~727

ADOPT: 410-141-3591

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3591
MCE Interoperability Requirements
(1) Interoperability and Access to Health Information¶
(a) MCEs shall comply with all federal regulations set forth in the CMS Interoperability and Patient Access Final Rule. ¶
(b) All MCEs shall review the Office of National Coordinator for Health Information Technology (ONC) 21st Century Cures Act Final Rule relating to determine the applicably of the rule to their organizations' s obligation to comply with the final rule. This includes the organization's status as an Actor and the applicability of information blocking.¶
(2) For the purpose of this rule, the following definitions shall apply:¶
(a) "Application Programming Interface" (API) - means a technological interface defining the kinds of programming calls or requests that may be performed against an underlying data source; ¶
(b) "Publicly Accessible'' means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;¶
(c) "Third-Party Application" means a computer program that is developed and distributed by an organization or individual other than that which owns, administers, or manufactures the data being accessed;¶
(d) "Data Sharing agreement" means a formal contract detailing what data are being shared and the appropriate use of those data;¶
(e) "Information blocking" means a practice by a health care provider, health IT developer, health information exchange, or health information network that, except as required by law or specified by the Secretary of Health & Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information.¶
(3) MCEs must implement and maintain standards-based APIs that permits Third-Party Applications to retrieve data, with the approval and at the direction of the current individual member or the member's personal representative through the use of common technologies, without special effort from the member or Data Sharing Agreement with the Third-Party Application. APIs must meet the following requirements:¶
(a) Interoperability requirements at 45 CFR 170.215 and technical requirements found at 422.119(c) including identity proofing and authentication processes that must be met by third-party application developers in order to connect to the API and access the specific member's data through the API;¶
(b) MCEs must comply with content and vocabulary standard requirements as applicable to the data type or data element found at 45 CFR 170.213 and 45 CFR part 162 and 42 CFR Part 406 423.160 unless alternate standards are required by other applicable law;¶
(c) For each API implemented, MCEs shall make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the following information:¶
(i) API syntax, function names, required and optional parameters supported and their data types, return variables

and their types/structures, exceptions and exception handling methods and their returns;¶
(ii) The software components and configurations that an application must use in order to successfully interact with the API and process its response(s); and¶
(iii) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.¶
(4) MCEs must conduct routine monitoring and testing and update as appropriate to ensure the API functions properly, including assessments to verify that the API is fully and successfully implementing privacy and security features to ensure compliance with all state and federal laws to protect the privacy and security of individually identifiable data.¶
(5) MCEs shall deny or discontinue any third-party application's connection to the API if it:¶
(a) Reasonably determines, consistent with its security risk analysis under 45 CFR part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of protected health information on the MCE's systems; and¶
(b) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all applications and developers through which members seek to access their electronic health information as defined at 45 CFR 171.102, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.¶
(6) MCEs must provide in an easily accessible location on their public website and through other appropriate mechanisms through which it ordinarily communicates with current and former members seeking to access their health information held by the MCE, educational resources in non-technical, simple and easy-to-understand language explaining at a minimum:¶
(a) General information on steps the member may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and ¶
(b) An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the US Department of Health and Human Services, Office of Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to both agencies.¶
(7) MCEs must implement and maintain a standards-based API that permits third-party applications to retrieve, with the approval and at the direction of a member or the member's personal representative, data specified in this section through the use of common technologies and without special effort from the member: ¶
(a) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances no later than one (1) business day after a claim is adjudicated;¶
(b) Data concerning adjudicated claims for prescription drug utilization including those carved out from MCE contracts, including remittances, no later than one (1) business day after a claim is adjudicated or carve-out utilization is reported to the MCE; ¶
(c) All encounter data, including encounter data from any network providers the MCE is compensating on the basis of capitation payments, adjudicated claims and encounter data from any subcontractors must be available no later than one (1) business day after data concerning the encounter is received by the MCE; ¶
(d) Clinical data, including laboratory results, if the MCE maintains any such data, no later than one (1) business day after the data is received by the MCE; and¶
(e) Formulary data that includes covered outpatient drugs, and any tiered formulary structure or utilization management procedure which pertains to those drugs.¶
(8) MCEs shall make provider directory information available publicly through a standards-based API. Information shall include provider names, addresses, phone numbers, and specialty. APIs shall be implemented consistent with 422.119. Information shall be updated no later than 30 calendar days after the MCE receives provider directory information or updates to provider directory information.
Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3805

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3805
Mandatory MCE Enrollment Exceptions
(1) In addition to the definitions in OAR 410-120-0000, the following definitions apply:¶
(a) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;¶
(b) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;¶
(c) "Renewal," means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.¶
(2) CCO enrollment is mandatory in all areas served by a CCO. A client eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.¶
(3) MCE enrollment is mandatory in service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:¶
(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or¶
(b) The member shall be enrolled with a CCO for physical health and behavioral health services and with a DCO for oral health services; or¶
(c) The member shall be enrolled with a CCO for behavioral health and oral health services and shall remain FFS for physical health services; or¶
(d) The member shall be enrolled with a CCO for behavioral health services and with a DCO for oral health services and shall remain FFS for physical health services; or¶
(e) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services and shall remain FFS for physical health services; or¶
(f) The member shall be enrolled with a DCO for oral health services and remain FFS for physical health and behavioral health services; or¶
(g) The member shall remain FFS for health care services if no MCE is available.¶
(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.¶
(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.¶
(6) Members who are exempt from physical health services shall receive behavioral health services and oral health services through an MCE:¶
(a) The member shall be enrolled with a CCO that offers behavioral health and oral health services; or¶

(b) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services; or¶
(c) The member shall be enrolled with a DCO for oral health services and shall remain FFS for behavioral health services if an MHO is not available; or¶
(d) The member shall remain FFS for both behavioral health and oral health services if neither a DCO nor an MHO is available.¶
(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:¶
(a) On or before Wednesday, the date of enrollment shall be the following Monday; or¶
(b) After Wednesday, the date of enrollment shall be one week from the following Monday.¶
(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:¶
(a) A newborn's services shall begin on the date of birth if the mother was a member of a CCO at the time of birth;¶
(b) For individuals other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;¶
(c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;¶
(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.¶
(9) Pursuant to ORS 414.631, the following populations may not be enrolled into an MCE for any type of health care coverage:¶
(a) Individuals who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;¶
(b) Clients with Medicare receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without another Medicaid;¶
(c) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).¶
(10) In addition, the following enrollment rules apply:¶
(a) A newly eligible OHP client who became eligible while admitted as an inpatient in a hospital, or while receiving post-hospital extended care (PHEC), is exempt from enrollment with a CCO for physical health and behavioral health services but not exempt from MCE enrollment oral health services with a DCO. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client, or until the member completes PHEC or the PHEC benefit is exhausted;¶
(b) A client may not be enrolled ~~in an MCE~~with a CCO if the client is covered under a major medical insurance policy, third party liability (TPL), or other third-party resource (TPR) that covers the cost of services to be provided by a~~n MCE~~ CCO as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800. ¶
(A) A client shall~~, however,~~ be enrolled with a DCO for oral health services even if they have a dental TPR.¶
(B) At the Authority's discretion, a client shall be enrolled with the highest level of CCO coverage, including physical health, behavioral health, and oral health services, if coverage through the TPR poses a safety risk to the member, specific to Good Cause determination as described in OAR 461-120-0350(1) and OAR 410-200-0220(6). In these situations:¶
(i) Recovery of third-party insurance should not be pursued; and¶
(ii) Explanation of Benefits (EOB) should be suppressed.¶
(11) Individuals who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from mandatory enrollment into an MCE, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.¶
(12) A child in the legal custody of the Department or where the child is expected to be in a substitute care

placement for less than 30 calendar days is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area unless:¶
(a) Access to health care on an FFS basis is not available; or¶
(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.¶
(13) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:¶
(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;¶
(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;¶
(c) A Full Medicare and Medicaid full dually eligible members may request to opt out of enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:¶
(A) Access to health care on an FFS basis is not available; or¶
(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;¶
(i) The development of a prior-authorized treatment plan;¶
(ii) Care management requirements based on the beneficiary's medical condition;¶
(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and¶
(iv) Need for individual case conferences to ensure a "warm hand-off."¶
(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:¶
(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;¶
(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;¶
(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.¶
(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;¶
(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.¶
(14) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:¶
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;¶
(b) The following apply to clients and exemptions relating to organ transplants:¶
(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;¶
(B) Newly eligible clients with existing transplants are not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care.¶

(15) MCE enrollment standards:¶
(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:¶
(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;¶
(B) Closed enrollment as a sanction for MCE misconduct.¶
(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;¶
(c) MCEs may confirm the enrollment status of a client by one of the following:¶
(A) The individual's name appears on the monthly or weekly enrollment list produced by the Authority;¶
(B) The individual presents a valid medical care identification that shows he or she is enrolled with the MCE;¶
(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the MCE;¶
(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the MCE.¶
(d) MCEs shall have open enrollment for 30 continuous calendar days during each 12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.¶
(16) If the Authority permits an MCE to assign its contract to another MCE, members shall be automatically enrolled in the MCE that has assumed the contract:¶
(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the MCE that has assumed the contract;¶
(b) If the MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.¶
(17) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area such that the MCE cannot meet the access to care requirements set forth in OAR 410-141-3515 and which necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:¶
(a) An MCE may provide less than the required 90-calendar-day notice to the Authority upon approval by the Authority when the MCE must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the MCE and refuses to provide the required 90-calendar-day notice;¶
(b) The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority shall instead notify members of a change in participating providers or MCEs. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~ORS 414.065
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727

AMEND: 410-141-3810

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3810
Disenrollment from MCEs
(1) Member-initiated requests for disenrollment.¶
(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule.¶
(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:¶
(A) Without cause:¶
(i) Members may request to change their MCE enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle.¶
(ii) Members may request to change their MCE enrollment within 90 calendar days of the initial MCE enrollment. If approved, the change would occur during the next weekly enrollment cycle.¶
(iii) Members may request to change their MCE enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month.¶
(iv) Members may request to change their MCE enrollment at their OHP eligibility renewal. If approved, the change would occur at the end of the month.¶
(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. If a request for disenrollment is approved under this section, the change would occur at the end of the month.¶
(B) With cause, at any time as follows:¶
(i) The member moves out of the MCE service area; or¶
(ii) Due to moral or religious objections the CCO does not cover the service the member seeks.¶
(iii) When the member needs related services (for example a Caesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.¶
(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to fee-for-service at any time subject to the provisions set forth in OAR 410-1413805(13)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition.¶
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include but are not limited to:¶
(i) The member is a American Indian or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;¶

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

the end of the month the TPL is reported. In s, with the exception of:¶
(i) When Good Cause determination is active or concurrently documented, in which case the member will retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(ii) Some situations, in which the Authority may approve retroactive disenrollment;.¶
(C) If a member has been residing outside the MCE's service area for more than three months unless previously arranged with the MCE. The MCE shall provide written documentation that the member has been residing outside its service area for more than three months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR will notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;¶
(D) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;¶
(E) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution; or¶
(F) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the MCE.¶
(G) The member had End Stage Renal Disease at the time of enrollment in the MCE.¶
(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.¶
(a) MCEs have the right to request the Authority disenroll members when they commit fraudulent or illegal acts related to participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts.¶
(b) The MCE shall report any illegal acts to law enforcement authorities and, if appropriate, to the DHS Fraud Investigations Unit.¶
(c) When requesting disenrollment based on a member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, including any verification of reports submitted to law enforcement and, if applicable, the DHS Fraud Investigations Unit.¶
(d) Based on the evidence presented, the CCO AR will review the disenrollment request and all submitted evidence with Authority staff. The review process will be documented and a recommendation for disenrollment will be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.¶
(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.¶
(a) Subject to applicable disability discrimination laws and this subsection (4), the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule.¶
(b) For purposes of this rule, a "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the MCE shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or the best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that

potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others.¶
(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:¶
(A) Physical, intellectual, developmental, or mental disability; or¶
(B) An adverse change in the member's health; or¶
(C) Under or over-utilization of services; or¶
(D) Filing a grievance or exercising any appeal or contested case hearing rights; or¶
(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or¶
(F) Uncooperative or disruptive behavior resulting from the member's special needs.¶
(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member.-The provider shall document the written notification to the MCE in the member's medical record.-¶
(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:¶
(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider.-The MCE shall document the education, training, and the resources or services furnished to the reporting provider.-¶
(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:-¶
(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;-¶
(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and-¶
(iii) Inform the member that their continued behavior may result in disenrollment from the MCE.¶
(C) In the event the interventions undertaken in accordance with Subsections (e)(B) of this rule do not ameliorate the member's uncooperative or disruptive behavior, the MCE shall Contact the member's care team, or develop a member focused care team if one does not already exist, to support the member in remediating their behavior. If needed, and with the consent of the member, the care team shall involve other appropriate individuals working with the member in the resolution within the laws governing confidentiality. The MCE shall facilitate cross functional care conferences that include the member, member focused care team, and other individuals chosen by the member with appropriate releases documented.-¶
(D) In the event the member's uncooperative or disruptive behavior continues after undertaking the efforts identified in subsections (e)(C) of this rule, the MCE shall convene an interdisciplinary team that includes a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior, their behavioral history, and previous efforts undertaken to manage the member's behavior, including those developed through the members care team and care conferences, in order to determine whether the member may be able to remediate their uncooperative or disruptive behavior through other reasonable clinical or social interventions.¶
(f) All efforts undertaken in connection with this section (4) of the rule, including, without limitation, all interventions, written and oral communications, training and education provided to the member and the member's provider(s), as well as those persons who participated in any and all interventions, care teams, assessments and the like, shall be documented in the member's MCE case file and as applicable, the provider shall document all efforts undertaken in the member's medical record.¶
(g) If, after undertaking all efforts identified in subsection (e) of this rule, the member's disruptive or

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

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

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

and¶
(B) The Authority has provided notice of a transfer to members affected by the transfer at least 90 calendar days before the scheduled date of the transfer.
Statutory/Other Authority: ORS 413.0~~32, 414.615, 414.625, 414.635, 414.651, 42 CFR 438.56, 42 CFR 455.13, 42 CFR 438.420~~42, 414.065
Statutes/Other Implemented: ~~ORS 414.610 -~~414.065, ORS 414.~~685~~727

AMEND: 410-141-3860

REPEAL: Temporary 410-141-3860 from DMAP 6-2021

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3860
Integration and Coordination of Care
(1) In order to achieve the objectives of providing CCO members integrated person-centered care and services, CCOs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs shall be required to document and report on the requirements in this rule in accordance with section (20) of this rule. ¶
(2) CCOs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs. ¶
(3) CCOs shall coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities: ¶
(a) With the services the member receives from any other CCO, and for FBDE members, from Medicare providers and, where applicable, MA or DSNP plans; ¶
(b) With the services the member receives in FFS Medicaid; and ¶
(c) With the services the member receives from community and social support providers. ¶
(4) CCOs shall develop evidence-based and, whenever possible, innovative flexible and creative strategies, for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs. ¶
(5) To the maximum extent feasible, CCOs shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs by: ¶
(a) Making PCPCHs the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management; ¶
(b) Developing and implementing mechanisms that encourage providers to communicate and coordinate care with PCPCHs in a timely manner, using electronic health information technology when the technology is available; and ¶
(c) Engaging other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity. ¶
(6) If, in addition to the use of PCPCH, a CCO implements other models of patient-centered primary health care, the CCO shall ensure member access to effective coordinated care services that include wellness and prevention services, active management and support of members with special health care needs, including those members receiving Medicaid long-term services and supports (LTSS), a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. To that end the CCO shall be required to: ¶
(a) Ensure each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type. If the member does not choose a primary care provider or primary care team within

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

requirements for CCO care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865. ¶
(9) CCOs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs as follows: ¶
(a) Establishing procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services; ¶
(b) Developing and entering into memoranda of understanding (MOUs) or contracts with the local type B Area Agency on Aging or the local office of the Department's APD that details their system coordination agreements regarding members receiving Medicaid-funded LTCSS; and ¶
(c) Developing and entering into MOUs or contracts with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget. For FBDE members, MCEs shall coordinate Medicare covered behavioral health benefits and Medicaid behavioral health benefits to ensure members receive appropriate and medically necessary care, including preventative screenings and assessments.¶
(10) CCOs shall cover and reimburse inpatient psychiatric services, except when those services are provided at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010 and OAR 410-141-3500. The state may, however, make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services provided at an IMD as an alternative setting to those covered under the state plan, when all of the following requirements are met in accordance with 42 CFR 438.6(e): ¶
(a) The member receiving services is aged 21-64; ¶
(b) The services are provided for a short-term of no more than 15 days during the period of the monthly capitation payment; and ¶
(c) The provision of services at the IMD meets the requirements for "in lieu of services" as set forth in 42 CFR 438.6(e)(2)(i) through (iii), which requires all of the following: ¶
(A) The IMD is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan; ¶
(B) The CCO must offer members the option to access the state plan services and shall not require members to use the IMD as an alternative service or setting; and ¶
(C) The approved in lieu of services are authorized and identified in the CCO contracts and offered to members at the CCO's option. ¶
(11) If a member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the CCO shall communicate with the member, the member's representative, and the Medicaid funded long-term care provider or facility, and the DHS or AAA case manager about integrated and coordinated care services. ¶
(12) CCOs shall ensure their participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. The CCOs shall also ensure that they facilitate information exchanges between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). Compliance with the requirements under this section (12) shall be documented and reported to the Authority in the form and manner required by the Authority in accordance with OAR 410-141-3525: ¶
(a) CCOs shall require that providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with their Health Equity Plan Training and Education described in 410-141- 3735; ¶

(b) CCOs shall communicate their integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities. ¶
(13) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. CCOs shall coordinate the care of members who enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the Oregon State Hospital and when they are transitioning out of the Oregon State Hospital. ¶
(14) Except as provided in OAR 410-141-3800, CCOs shall coordinate a member's care outside the CCO's service area or, when medically necessary specialty care is not available in Oregon, out-of-state care. CCOs shall coordinate member care even when services or placements are outside the CCO service area. Temporary placements by the Authority, Department, or providers who are responsible for health service placements for services including residential placements, may be located outside the service area; however, the CCO shall coordinate care while in placement and discharge planning for return to the home CCO. For out of service area placements, an exception shall be made for the member to retain home CCO enrollment while the member's placement is a temporary residential placement as defined in OAR 410-141-3500, or elsewhere in accordance with OAR 410-141-3815. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan when the member returns to their home CCO as defined on OAR 410-141-3500. ¶
(15) CCOs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay for the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 CCO Service Authorization. ¶
(16) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing behavioral health crises and to prevent inappropriate use of the emergency department or jails. ¶
(17) CCOs shall perform care coordination in a manner that is trauma-informed, culturally responsive, and which promotes dignity for individuals with disabilities or chronic conditions, as those terms are defined in OAR 410-141-3500. ¶
(18) CCOs shall implement at least one outcome measure tool for care coordination services at the ICC Care Coordination level. CCOs shall collaborate with the Authority to develop statewide standards for care coordination and ICC. ¶
(19) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a Care Coordination report submitted to the Authority ~~semi-annually beginning in the second half of 2021. Beginning in~~under the following timelines:¶
(a) For the reporting period of April 1, 2021 through September 30, 2021, reports shall be prepared as two quarterly reports, each of which must be submitted to the Authority within 60 calendar days from the end of the corresponding calendar quarters;¶
(b) CCOs will not be required to submit a report for the period of October 1, 2021 through December 31, 2021;¶
(c) Beginning in Calendar Year 2022, CCOs shall submit ~~reports semi-annually on~~semi-annual reports for the reporting periods of January 1 through June 30~~th~~ and ~~December 31st.~~July 1 through December 31, each of which must be submitted to the Authority within 60 calendar days from the end of the corresponding reporting period.¶
(d) The CCO is subject to appropriate corrective action by the Authority if the contents of the report reveal that the CCO's care coordination requirements are not being met. For each reporting period the report must contain: ¶
(~~a~~A) Identification of care coordination services used with members and the frequency with which each of those practices were used; ¶
(~~b~~B) Identification of the number of members who qualify for ICC services; ¶

(~~c~~C) Identification of the number of members receiving ICC services, the type of ICC services provided, and the demographics of such members, consistent with REALD reporting requirements found in OAR<u>s</u> 943-070-0000 through 943-070-0070; ¶
(~~d~~D) An overall review of care coordinators performing services for the CCO, separated by employed and delegated or subcontracted care coordinators; ¶
(~~e~~E) Identification of any significant events that occurred to members, including, without limitation: ¶
(~~A~~i) Incarceration; ¶
(~~B~~ii) Reassessment triggers; and ¶
(~~C~~iii) Sentinel events. For the purpose of this rule, Sentinel Event is defined as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness; ¶
(~~f~~F) Data on the type and frequency of reassessment triggers; ¶
(~~g~~G) Identification of the number of members who received services in coordination with MA or DSNP plans and Medicaid funded LTSS programs and services;¶
(~~h~~H) Plans and strategies to improve care coordination with network providers; ¶
(~~i~~I) Identification of milestones and accomplishments; and ¶
(~~j~~J) A plan to improve the overall process of care coordination access for its Members. The plan shall also include discussion of gaps in care coordination services and populations that need additional support and plans for improving the care coordination system within their CCO. The plan is subject to approval by the CCOs' governing boards.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~<u>ORS 414.065</u>
Statutes/Other Implemented: ORS 414.~~610 -~~<u>065,</u> 414.~~685~~<u>727</u>

AMEND: 410-141-3875

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3875
MCE Grievances & Appeals: Definitions and General Requirements
(1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:¶
(a) "Appeal" means a review by an MCE, pursuant to OAR 410-141-3890 of an adverse benefit determination;¶
(b) "Adverse Benefit Determination" means any of the following, consistent with 42 CFR 438.400(b):¶
(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;¶
(B) The reduction, suspension, or termination of a previously authorized service;¶
(C) ~~The~~A denial, in whole or in part, of a payment for a service. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination;¶
(D) The failure to provide services in a timely manner pursuant to 410-141-3515;¶
(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;¶
(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or¶
(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.¶
(c) "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. For the purpose of this rule, pharmacy claims processed at point-of-sale (POS) that are rejected or denied shall not be considered "clean claims" that would trigger an NOABD;¶
(d) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;¶
(~~d~~e) "Continuing benefits" means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910;¶
(~~e~~f) "Grievance" means a member's expression of dissatisfaction to the MCE or to the Authority about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision;¶
(~~f~~g) "Member." With respect to actions taken regarding grievances and appeals, references to a "member" include, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to MCE notification requirements, a separate notice must be sent to each individual who falls within this definition;¶
(~~g~~h) "Notice of Adverse Benefit Determination" means the notice must meet all requirements found at 42 CFR 438.400.¶
(2) MCEs shall establish and have an Authority approved process and written procedures for compliance with

grievance and appeals requirements that shall include the following:¶
(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;¶
(b) Member rights to appeal and request an MCE review of a notice of action/adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;¶
(c) Member rights to request a contested case hearing regarding an MCE notice of action/adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;¶
(d) An explanation of how MCEs shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;¶
(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;¶
(f) Specific to the appeals process, the policies shall:¶
(A) Consistent with confidentiality requirements, ensure the MCE's staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;¶
(B) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;-¶
(C) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;¶
(D) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and¶
(E) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.¶
(3) The MCE shall provide information to members regarding the following:¶
(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;¶
(b) Member rights and responsibilities; and¶
(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.¶
(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR □□ 438.408(b)(1) and (2) and these rules.¶
(5) Upon receipt of a grievance or appeal, the MCE shall:¶
(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;¶
(b) Give the grievance or appeal to staff with the authority to act upon the matter;¶
(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;¶
(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:¶
(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;¶
(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:¶
(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;¶
(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.¶
(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;¶

(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.¶
(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.¶
(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.¶
(8) The following pertains to the release of a member's information:¶
(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:¶
(A) Resolving the matter; or¶
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.¶
(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.¶
(9) The MCE shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:¶
(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;¶
(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR 438.10;¶
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and¶
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.¶
(10) The MCE, its subcontractors, and its participating providers may not:¶
(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;¶
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or¶
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.¶
(11) In all MCE administrative offices and in those physical, behavioral, and oral health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:¶
(a) OHP Complaint Form (OHP 3001);¶
(b) MCE appeal forms~~;~~¶
~~(c) Hearing request form (MSC 443) and Notice of Hearing Rights~~ (OHP 3302; or approved facsimile);¶
(c) Hearing request form Request to Review a Health Care Decision (OHP 3~~0~~302)~~;~~ or¶
~~(d) The Health Systems Division Service Denial Appeal and Hearing Request form~~ (MSC 443) and Notice of Hearing Rights (OHP 30302)~~;~~ or ~~approved facsimile.~~¶
(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.¶
(13) If at the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.¶

(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:¶
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;¶
(b) Monitor the subcontractor's performance on an ongoing basis;¶
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and¶
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
Statutory/Other Authority: ORS 413.0~~32, 414.615, 414.625, 414.635,~~42, ORS 414.0651~~~~
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727

AMEND: 410-141-3885

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3885
Grievances & Appeals: Notice of Action/Adverse Benefit Determination
(1) When an MCE has made an adverse benefit determination, the MCE shall notify the requesting provider and give the member and the member's representative a written notice of action/adverse benefit determination notice. The notice shall:¶
(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;¶
(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule;.¶
(c2) The following are notice requirements for pre-service denials:¶
(a) Meet the content notice requirements specified in 42 CFR § 438.404 and in the MCE contract, including the following information:¶
(A) Date of the notice;¶
(B) MCE's name, address, and telephone number;¶
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;MCE contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages; ¶
(B) Date of the notice;¶
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model; If the member has not been assigned a practitioner because they enrolled in the MCE within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred. ¶
(D) Member's name, date of birth, address, and OHP member ID number;¶
(E) Service requested or previously provided and the adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment;¶
(F) Date of the service or d;¶
(F) Date service was requested by the provider or member;¶
(G) Name of the provider who performed or requested the service;¶
(H) Effective date of the adverse benefit determination if different from the date of the notice;¶
(I) Diagnosis and procedure codes submitted with the authorization request including a description in plain language if the MCE is denying a requested service because of line placement on the Prioritized List of Health Services or the diagnosis and procedure code do not pair on the Prioritized List;¶
(J) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830;¶

(~~J~~K) Clear and thorough explanation of the specific reasons for the adverse benefit determination;¶
(~~K~~L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶
(~~L~~M) The member's or, if the member provides their written consent as required under OAR 410-141-3890(1), the provider's right to file a~~n~~ written or oral appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(~~M~~N) The member's or the provider's right to request a contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;¶
(~~N~~O) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it; ¶
(~~O~~P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and¶
(~~P~~Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination.¶
(~~d~~b) Use an Authority approved ABD notice form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the Oregon's Notice of A~~ction/A~~dverse Benefit Determination.¶
(3) The following are notice requirements for Post-service denials:¶
(a) Meet the content notice requirements specified in 42 CFR 438.404 and in the MCE contract, including the following information:¶
(A) MCE contact information and subcontractor contact information, if applicable, included in the ABD notice excluding any cover pages;¶
(B) Date of the notice;¶
(C) MCE's name, address, and telephone number;¶
(D) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last 30 days, the NOABD should state PCP, PCD, BH provider assignment has not occurred; ¶
(E) Member's name, D.O.B, address, and OHP member ID number;¶
(F) Service previously provided and the adverse benefit determination the MCE made;¶
(G) Date the service was provided;¶
(H) Name of the provider who provided the service;¶
(I) Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;¶
(~~2~~J) ~~The MCE shall provide copies of the following forms when the MCE iss~~Diagnosis and procedure codes submitted on the claim including a description in plain language if the MCE is denying the service because of line placement on the Prioritized List of Health Services or the diagnosis and procedure code do not pair on the Prioritized List;¶
(K) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830;¶
(L) Clear and thorough explanation of the specific reasons for the adverse benefit determination;¶
(M) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶
(N) The member's or, if the member provides their written consent as required under OAR 410-141-3890(1), the

provider's right to file a written or oral appeal of the MCE's adverse benefit determination with the MCE, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(O) The member's or the provider's right to request a ~~Notice of Adverse Benefit Determination:¶~~
~~(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or¶~~
~~(b) The Health Systems Division Service Denial~~contested case hearing with the Authority only after the MCE's Appeal Notice of Resolution or where the MCE failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;¶
(P) An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it but that an expedited appeal and hearing will not be granted for post-service denials as the service has already been provided; ¶
(Q) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; ¶
(R) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination; and¶
(S) A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166). ¶
(b) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the Oregon's Notice of Action/Adverse Benefit Determination.¶
(4) The MCE shall provide a copy of the form, Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile, when the MCE issues a Notice of Adverse Benefit Determination .¶
(~~3~~5) For requirements of notice of actions/adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.¶
(~~4~~6) In 42 CFR □□ 431.213 and 431.214, exceptions related to advance notice include the following:¶
(a) The MCE may mail the notice no later than the date of adverse benefit determination if:¶
(A) The MCE has factual information confirming the death of the member;¶
(B) The MCE receives notice that the services requested by the member are no longer desired or the MCE is provided with information that requires termination or reduction in services:¶
(i) All notices sent ~~by~~to a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;¶
(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested. ¶
(C) The MCE can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;¶
(D) The MCE is unaware of the member's whereabouts and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;¶
(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or¶
(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.¶
(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE:¶
(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and¶

(B) The MCE has verified those facts, whenever possible, through secondary resources.¶
(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.¶
(~~5~~7) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.
Statutory/Other Authority: ORS 414~~.0~~3.0~~32, 414.615, 414.625, 414.635,~~42, ORS 414.065~~1~~
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727

AMEND: 410-141-3890

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3890
Grievances & Appeals: Appeal Process
(1) A member, member representative, or a subcontractor or provider with the member's written consent, may file an oral or written appeal with the MCE to:¶
(a) Express disagreement with an adverse benefit determination; or¶
(b) Contest the MCE's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.¶
(2c) AOral appeals ~~may be initiated orally or in writing, subject to the following requirements:¶~~
~~(a) The MCE shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;¶~~
~~(b) The MCE is considered to have satisfied this duty if the MCE has already made~~timeframes shall begin when there is established contact made between the member and an MCE representative. If the member leaves a voice mail message with the MCE indicating that they wish to appeal a denial the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt~~s~~ to ~~assist~~reach the member ~~in filling out the necessary forms to file a written~~(date(s) and time(s)) by phone and make note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.¶
(3~~2~~) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.¶
(4~~3~~) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:¶
(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;¶
(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:¶
(A) The member requests the extension; or¶
(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.¶
(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:¶
(A) Make reasonable efforts to give the member prompt oral notice of the delay;¶
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.¶
(4) For expedited resolution of an appeal please see OAR 410-141-3895. A request for an expedited appeal for a service that has already been provided to the member (post-service) will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above in (3).¶
(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.¶
(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:¶
(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest

possible filing date~~, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal~~;¶
(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.¶
(7) Parties to the appeal include, as applicable:¶
(a) The MCE and the member; or¶
(b) The MCE and the member's provider.¶
(8) The MCE shall resolve each standard appeal in time period defined above in section (4). The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.¶
(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.¶
(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the ~~s~~State shall pay for those services in accordance with the Authority policy and regulations.¶
(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:¶
(a) The results of the resolution process and the date the MCE completed the resolution; and¶
(b) For appeals not resolved wholly in favor of the member:¶
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;¶
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;¶
(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and¶
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;¶
(E) Copies of the appropriate forms:¶
(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or¶
(ii) ~~The Health Systems Division Service Denial~~Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.
Statutory/Other Authority: ORS 413.0~~32~~42, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3895

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3895
Grievances & Appeals: Expedited Appeal
(1) Each MCE shall establish and maintain an expedited review process for all oral and written appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860. ¶
~~(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.¶~~
~~(3~~ Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative.¶
(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.¶
(3) A request for an expedited appeal for a service that has already been provided (post-service) to the member will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth in 410-141-3890 (4).¶
(4) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:¶
(a) Inform the member of the limited time available for receipt of materials or documentation for the review;¶
(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; ~~and~~¶
(c) Mail written confirmation of the resolution to the member within three days;¶
(d) Extend the timeframes by up to 14 days if:¶
(A) The member requests the extension; or¶
(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.¶
(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:¶
(A) Make reasonable efforts to give the member prompt oral notice of the delay;¶
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.¶
(45) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.¶
(~~5~~6) If the MCE denies a request for expedited resolution on appeal, the MCE shall:¶
(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;¶
(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.¶
~~[NOTE: Forms referenced are available from the agency.]~~

Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3905

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3905
Grievances & Appeals: Expedited Contested Case Hearings
(1) An MCE shall have a system in place to ensure its members and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.¶
(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.¶
(3) A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.¶
(4) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with the MCE, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.¶
(45) Expedited hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.¶
(56) The MCE shall submit relevant documentation to the Authority within two working days. The Authority shall decide within two working days from the date of receiving the relevant documentation whether the member is entitled to an expedited contested case hearing.¶
(67) If the Authority denies a request for an expedited contested case hearing, the Authority shall:¶
(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and¶
(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.¶
(78) If a member requests an expedited hearing, the Authority shall request documentation from the MCE, and the MCE shall submit relevant documentation including clinical documentation to the Authority within two working days.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651ORS 414.065
Statutes/Other Implemented: ORS 414.610 -065, 414.685727

AMEND: 410-141-3915

NOTICE FILED DATE: 05/11/2021

RULE SUMMARY: This semi-annual rule filing is necessary to ensure continued access to health services for OHP members enrolled in CCOs.
Proposed revisions are to align with changes in the changes in federal law and other policy initiatives to ensure adequate oversight of CCOs and protection of OHP member rights. A new rule on Interoperability Requirements for Managed Care Entities is necessary to ensure MCE compliance with federal regulations effective July 1, 2021.

CHANGES TO RULE:

410-141-3915
Grievances & Appeals: System Recordkeeping
(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.¶
(2) Consistent with record retention requirements in OAR 410-141-3520, MCE's must maintain yearly logs of all appeals and grievances for 10 years, which must include information about the reasons for each grievance or appeal, as well as the resolution and supporting reasoning.¶
(3) The MCE must review the log monthly for completeness, accuracy, and compliance with required procedures.¶
(4) MCE's shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.¶
(5) The Grievance System Report and Grievance and Appeals Log shall be forwarded to the MCE's Quality Improvement committee to comply with the Quality Improvement standards as follows:¶
(a) Review of completeness, accuracy, and timeliness of documentation;¶
(b) Compliance with written procedures for receipt, disposition, and documentation; and¶
(c) Compliance with applicable OHP rules.
Statutory/Other Authority: ORS 413.042, ~~414.615, 414.625, 414.635, 414.651~~ORS 414.065
Statutes/Other Implemented: ORS 414.~~610 -~~065, 414.~~685~~727