OFFICE OF THE SECRETARY OF STATE
SHEMIA FAGAN
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 36-2022
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
02/25/2022 4:45 PM
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FILING CAPTION: Indian Managed Care Entities

EFFECTIVE DATE: 03/01/2022 THROUGH 08/27/2022

AGENCY APPROVED DATE: 02/24/2022

CONTACT: Nita Kumar
503-847-1357
hsd.rules@state.or.us

500 Summer St NE
Salem,OR 97301

Filed By:
Nita Kumar
Rules Coordinator

NEED FOR THE RULE(S):

These rules are needed to govern operation of the Indian Managed Care Entity program.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may fulfill a request from our tribal partners to establish and operate the first Indian Managed Care Entity program in the United States. These rules are necessary to upload our government to government commitment.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

ADOPT: 410-146-5000

RULE SUMMARY: Creates ruleset for Indian Managed Care Entity program.

CHANGES TO RULE:

410-146-5000
Indian Managed Care Entities
(1) Definitions. The definitions in OAR 410-141-3500 apply to this rule unless context dictates otherwise. In addition, for purposes of this rule:¶
(a) "The Authority" means the Oregon Health Authority;¶
(b) "Contract" means an agreement between the State of Oregon and an Indian Managed Care Entity to provide Primary Care Case Management services to eligible members;¶
(c) "Indian Managed Care Entity (IMCE)" means a managed care entity that is controlled by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium thereof, as described in 42 U.S.C. § 1396u-2(h)(4)(B) and 42 C.F.R. § 438.14(a);¶
(d) "Client" means an Oregon Health Plan client who is American Indian or Alaska Native (AI/AN) as 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).;¶
(e) "Member" means a client enrolled with an IMCE;¶
(f) "Primary Care Case Management (PCCM) Services" means the location, coordination and monitoring of primary health care services for members. PCCM services may include:¶
(A) The provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line;¶
(B) The development of enrollee care plans;¶
(C) The execution of contracts with, or oversight responsibilities for, the activities of fee-for-service (FFS) providers in the FFS program;¶
(D) The provision of payments to FFS providers on behalf of the State;¶
(E) The provision of enrollee outreach and education activities;¶
(F) The operation of a customer service call center;¶
(G) Review of provider claims, utilization, and practice patterns to conduct provider profiling or practice improvement;¶
(H) Implementation of quality improvement activities, including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers;¶
(I) Coordination with behavioral health systems/providers; and¶
(J) Coordination with long-term services and supports systems/providers.¶
(2) IMCE PCCM Services: General Standard. The Authority will reimburse an IMCE for PCCM services furnished to eligible members in accordance with a duly executed IMCE contract. The Authority shall ensure that:¶
(a) All necessary federal approvals are obtained in order to ensure the availability of federal financial participation for PCCM services furnished by IMCEs;¶
(b) IMCE contracts are executed in accordance with, and require IMCEs to comply with:¶
(A) Applicable federal law, including 42 U.S.C. 1396u-2(h) and 42 C.F.R. Part 438; and¶
(B) Applicable state law, including this rule.¶
(3) Reimbursement. An IMCE will receive a Per Member Per Month payment, calculated by the Authority in accordance with the contract. This payment will be prorated for any member who is enrolled for less than a full month.¶
(a) IMCE payments will be generated on a monthly basis.¶
(b) Should the Authority identify an overpayment (due to, for example, member disenrollment or ineligibility), the overpayment will be recouped from subsequent IMCE payments.¶
(4) Member Attribution: IMCEs Operated by a Tribe or Tribal Organization.¶
(a) An individual is potentially eligible to enroll in a Tribal IMCE if the individual:¶
(A) Is an American Indian or Alaska Native, as 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)¶
(B) May reside within the Tribe's purchased and referred care service delivery area (PRCDA);¶
(C) Is enrolled in the OHP; and¶
(D) Is not currently enrolled with another IMCE or a Coordinated Care Organization (CCO).¶
(b) A Tribal IMCE has the discretion to decide which eligible individuals to enroll and how many eligible individuals to enroll, subject to compliance with:¶
(A) Any applicable contract provisions; and¶
(B) Applicable state and federal laws that prohibit discrimination based on disability and other protected traits.¶
(c) The IMCE will, on a monthly basis, submit to the Authority a patient attribution form listing the IMCE's enrolled members, as specified in the contract. The Authority will confirm the eligibility of all members before processing IMCE payments.¶
(5) Member Attribution: IMCEs Operated by an Urban Indian Organization.¶
(a) An individual is potentially eligible to enroll in an Urban Indian IMCE if the individual:¶
(A) Is an American Indian or Alaska Native, as defined in OAR 410-141-3500;¶
(B) Resides within the service area designated in the contract;¶
(C) Is enrolled in the OHP; and¶
(D) Is not currently enrolled with another IMCE or a CCO.¶
(b) In accordance with the contract, the Authority will periodically generate and submit to the Urban Indian IMCE a list of individuals that meet the eligibility criteria under subsection (5)(a).¶
(c) An Urban Indian IMCE has the discretion to decide which eligible individuals to enroll and how many eligible individuals to enroll, subject to compliance with:¶
(A) Any applicable contract provisions; and¶
(B) Applicable state and federal laws that prohibit discrimination based on disability and other protected traits.¶
(6) Enrollment. IMCEs shall comply with applicable contract provisions regarding member enrollment and communication with new members.¶

(7) Disenrollment. IMCEs are responsible for processing, and notifying the Authority of, member disenrollments, in accordance with applicable contract provisions.¶
(a) Disenrollments initiated by members. Members have a right to request disenrollment from an IMCE at any time.¶
(b) Disenrollments initiated by the IMCE.¶
(A) An IMCE must disenroll any member who is no longer eligible for IMCE PCCM services.¶
(B) An IMCE may disenroll any member at any time, subject to compliance with subparagraph (7)(b)(C) and any applicable contract provisions.¶
(C) An IMCE may not select members for disenrollment based on factors that would violate applicable state and federal laws that prohibit discrimination based on disability and other protected traits. In addition, consistent with 42 C.F.R. § 438.56(b)(2), an IMCE may not disenroll a member solely due to:¶
(i) An adverse change in the member's health status;¶
(ii) The member's utilization of medical services;¶
(iii) The member's diminished mental capacity; or¶
(iv) The member's uncooperative or disruptive behavior resulting from special needs (except when the member's continued enrollment seriously impairs the IMCE's ability to furnish services to either this particular member or other members).¶
(8) IMCE Member Rights & Responsibilities. An IMCE shall, in accordance with the contract, develop written policies defining member rights and responsibilities, ensuring that members are aware of those rights and responsibilities, and enabling members to exercise their rights.¶
(a) At a minimum, members have the right to:¶
(A) Be treated with dignity and respect;¶
(B) Have choice of one or more friends, family members, member representatives, and/or advocate present during communications with IMCE staff;¶
(C) Be actively involved in the development of their care plan;¶
(D) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency in language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual and, as applicable, the legal representative or authorized representative of the individual;¶
(E) Have written materials explained in a manner that is understandable to the member and be educated about the PCCM model;¶
(F) Have a clinical record maintained that documents conditions, services received, and referrals made;¶
(G) Have access to one's own clinical record, unless restricted by federal regulations or state statute;¶
(H) Transfer of a copy of the clinical record to another provider; and¶
(I) Be able to make a complaint ("grievance") with the IMCE and receive a response.¶
(b) At a minimum, members have the responsibility to:¶
(A) Treat the IMCE staff members with respect;¶
(B) Give accurate information for inclusion in the clinical record;¶
(C) Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;¶
(D) Ask questions about conditions, treatments, and other issues related to care that is not understood;¶
(E) Help in the creation of a care plan;¶
(F) Inform the IMCE or the Authority of a change of address or phone number; and¶
(G) Bring issues or complaints or grievances to the attention of the IMCE.¶
(9) Grievance System. An IMCE must establish a system for member grievances that complies with OAR 410-141-3875 through 410-141-3880, OAR 410-141-3915, and any applicable contract provisions. (An IMCE that does not make service authorization decisions is not required to establish processes for member appeals or contested case hearings.)¶
(10) Application of Oregon Health Plan Regulations. Subject to the scope of the IMCE contract and to the definitions in subsection (1) above, the following rules apply to IMCEs as though, in these rules, all instances of the term "MCE" were replaced with "IMCE":¶
(a) OAR 410-120-0000 (Acronyms and Definitions);¶
(b) OAR 410-141-3530 (Definitions);¶
(c) OAR 410-141-3501 (Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence);¶
(d) OAR 410-141-3505 (Use of Subcontractors);¶
(e) Sections (9) through (13) of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology);¶
(f) OAR 410-141-3530 (Sanctions);¶

(g) OAR 410-141-3550 (Resolving Disputes with OHA);¶
(h) OAR 410-141-3575 (Member Relations, Marketing);¶
(i) OAR 410-141-3580 (Potential Member Information);¶
(j) OAR 410-141-3585 (Member Relations: Education and Information); and¶
(k) Sections (1) through (10) of OAR 410-141-3710 (Contract Termination and Close-Out Requirements).
Statutory/Other Authority: ORS 413.042, 42 U.S. Code § 1396u-2, 42 CFR § 438.14
Statutes/Other Implemented: