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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
09/30/2025 10:22 AM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Update and clarify rules for Coordinated Care Organizations, including changes resulting from 2025 legislative session

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/21/2025 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/16/2025
TIME: 2:30 PM - 4:00 PM
OFFICER: Brenna Bird

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1601329211
SPECIAL INSTRUCTIONS:
Topic: Public Hearing 410-141 CCO Rules
Time: Oct 16, 2025 02:30 PM Pacific Time (US and Canada)
Join ZoomGov Meeting
https://www.zoomgov.com/j/1601329211?pwd=yIfB65Gq1WmEsoL9uVwYbKgedb45QH.1

Meeting ID: 160 132 9211
Passcode: 490974

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NEED FOR THE RULE(S)

Update and clarify language to better ensure Coordinated Care Organization (CCO) compliance with federal Medicaid rules. Incorporate changes reflecting passage of House Bills 2205, 2208 and 2211 and Senate Bills 296, 549 and 831 during 2025 legislative session. Revise rules to align with changes reflected in 2026 CCO Model Contract distributed to CCOs in September 2025. Implementation of the proposed language to increase the post-hospitalization extended care benefit from 20 days to 100 days per SB 296 is pending CMS approval.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

HB 2205 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2205/Enrolled
HB 2208 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2208/Enrolled
HB 2211 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2211/Enrolled
SB 296 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB296/Enrolled (see Section 6)
SB 549 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB549/Enrolled
SB 831 - https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB831/Enrolled
CCO Model 2026 Contract - To be posted at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx
WCAG 2.2 - https://www.w3.org/TR/WCAG22/
42 CFR §440.230(e)(1) - https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-B/section-440.230 (standard prior authorization timeline)

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Most changes included in this rulemaking do not have a direct impact on OHP members. Of those that do, they will generally increase the level of a benefit or increase the speed in which the benefit can be accessed for all members.

FISCAL AND ECONOMIC IMPACT:

RAC participants indicated fiscal impact was expected as the result of rule changes reducing the time to process prior authorizations, requiring administrative work to revise materials to reflect changing the name of “Health-Related Services” to “Flexible Services” and increasing the post-hospital extended care benefit. OHA confirmed that these and all other changes included in the 2026 CCO decision draft contract were considered in setting 2026 capitation rates.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1. No fiscal impact anticipated
2(a). Providers contracting with CCOs may be impacted indirectly
2(b). None
2(c). None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

OHP providers were invited to participate in the RAC

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-141-3500, 410-141-3505, 410-141-3510, 410-141-3525, 410-141-3570, 410-141-3575, 410-141-3591, 410-141-3700, 410-141-3715, 410-141-3730, 410-141-3735, 410-141-3810, 410-141-3835, 410-141-3845, 410-141-3855, 410-141-3870, 410-141-3885, 410-141-3890, 410-141-3900, 410-141-3955, 410-141-3960, 410-141-5015, 410-141-5285, 410-141-5318

AMEND: 410-141-3500

RULE SUMMARY: Define “Dental Subcontractor”, “Flexible Services” “Local Mental Health Authority”, and “Local Planning Committee”, update definition of “Readily Accessible”, and make other clarifications.

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR chapter 410, division 141. The Oregon Health Authority (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 Managed Care Entity (MCE) claims decision or the Authority issuing a final hearings decision. For a final Managed Care Entity (MCE) claims decision, the date of "Adjudication" is the date on which an MCE has both (a) processed and (b) either paid or denied a Member's claim for services.¶
(3) "Aging and People with Disabilities (APD)" means the division in the Oregon Department of Human Services (ODHS) 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 ODHS 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 (OHA).¶
(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; Centers for Medicare and Medicaid Services (CMS) Section 1557 of the Affordable Care Act (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 Code of Federal Regulations (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 ~~T~~the Authority are in effect.¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday recognized by the State of Oregon. The word "day" not qualified as business day means calendar day.¶
(11) "Capitated Services" means those covered services that a~~n~~ Managed Care Entity (MCE) agrees to provide for a capitation payment under contract with the Authority.¶
(12) "Capitation Payment" means monthly prepayment to a Managed Care Entity (MCE) for capitated services to Managed Care Entity (MCE) members.¶
(13) "Care Coordination" means the act and responsibility of CCOs to deliberately organize a Member's overall benefits, services, care activities (e.g., assessments, case management, care planning) and information sharing among a ~~M~~member's care team, according to the physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the Member. Care Coordination requirements are described in OAR 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with 42 CFR 438.208.¶
(14) "Care Plan" means a document (digital or paper) that is developed for and in collaboration with the Member, their family, representatives or guardian, to the extent they desire or are able to participate, and in consultation

with the Member's providers, community supports and services, where applicable, to ensure continuity and coordination of a Member's care according to their needs. Care Plan requirements are described in OAR 410-141-3865 and 410-141-3870.¶
(15) "Care Profile" means the electronic health record a CCO develops and maintains for all ~~M~~members. The Care Profile is the platform that receives feeds from different data sources used to identify, track and manage a Member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the Member including, but not limited to, care management and appropriate Care Plans. Care Profile requirements are further described in OAR 410-141-3865 and OAR 410-141-3870.¶
(16) "Care Setting Transitions" means a transition between different locations, settings or levels of care.¶
(17) "Certificate of Authority" means the certificate issued by Department of Consumer and Business Services (DCBS) to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.¶
(18) "Client" means an individual found eligible to receive Oregon Health Plan (OHP) health services, whether or not the individual is enrolled as an CCO member.¶
(19) "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 414.572 and in accordance with criteria specified in ORS 414.575. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:¶
(a) In a Service Area where only one (1) federally recognized tribe exists, the CCO shall seek one (1) tribal representative to serve on the CAC;¶
(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one (1) tribal representative from each tribe to serve on the CAC; and¶
(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.¶
(20) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.¶
(21) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:¶
(a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to;¶
(A) Alcohol;¶
(B) Illicit Drugs; and¶
(C) Gambling.¶
(b) Physical Health conditions, including but not limited to:¶
(A) Cancer;¶
(B) Diabetes;¶
(C) Bariatric Care.¶
(c) Developmental Disabilities.¶
(22) "Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.¶
(23) "Contract" means an agreement between the State of Oregon acting by and through The Authority and a Managed Care Entity (MCE) to provide health services to eligible members.¶
(24) "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 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.¶
(25) "Coordinated Care Organization Payment or CCO Payment" means the monthly payment to a Coordinated Care Organization (CCO) for services the CCO provides to members in accordance with the global budget.¶
(26) "Coordinated Care Services" means a Managed Care Entity's (MCE) fully integrated physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) services.¶
(27) "Corrective Action" or "Corrective Action Plan (CAP)" means an Authority-initiated request for a Managed Care Entity (MCE) or a Managed Care Entity (MCE)-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.¶
(28) "Culturally and Linguistically Responsive and Appropriate Services" means the provision of effective,

equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and Linguistically appropriate services are further defined in 42 CFR § 59.2.¶
(29) "Delivery System Network (DSN)" means the entirety of those Participating Providers who:¶
(a) Contracts with; or¶
(b) Are employed by, a CCO for purposes of providing services to the Members of such CCO. "Provider Network" has the same meaning.¶
(30) "Dental ~~Care Organization (DCO)~~Subcontractor" has the meaning as provided for in ~~ORS 414.025 (24)~~410-120-0000.¶
(31) "Department" means the Oregon Department of Human Services (ODHS).¶
(32) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.¶
(33) "Disenrollment" means the act of removing a member from enrollment with an MCE.¶
(34) "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.¶
(35) "Downstream Entity" means any party that enters into a written contract or other agreement with a CCO's subcontractor pursuant to which such party performs one or more of the obligations of the Subcontractor under the subcontractor's subcontract with the CCO. Regardless of the number of parties that are downstream from a CCO's subcontractor, a party is deemed a "downstream entity" of a CCO subcontractor if such party is, pursuant to a written or oral contract or agreement, performing the obligations the subcontractor is required to perform on behalf of the CCO under its subcontract therewith.¶
(36) "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818 and under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided:¶
(a) Were covered services, non-covered services, or other Health-Related Social Needs services; or¶
(b) Were not paid; or¶
(c) Paid for on a Fee- For-Service or capitated basis; or¶
(d) Were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and¶
(e) Were performed pursuant to Subcontractor agreement, special arrangement with a facility or program, or other arrangement.¶
(37) "Enrollment" means the assignment of a member to a Managed Care Entity (MCE) for management and coordination of health services.¶
(38) "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 inserted 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.¶
(39) "Flexible Services" means ~~those services that are cost-effective services offered as an adjunct to covered benefits~~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.¶
(40) "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.¶
(41) "Grievance System" means the overall system that includes:¶
(a) Grievances to a Managed Care Entity (MCE) on matters other than adverse benefit determinations;¶
(b) Appeals to a Managed Care Entity (MCE) on adverse benefit terminations; 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.¶
(42) "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.¶
(43) ~~"Health-Related Services (HRS)" 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.¶~~
~~(44)~~ "Health Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a Member, their representative or guardian about key areas of the Member's health, including their physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity). The HRA is intended to inform the coordination of services and supports that meet the Members individualized needs as described in OAR 410-141-3860, 410-141-3865 and 410-141-3870.¶
(4~~5~~4) "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 Oregon Health Plan (OHP).¶
(4~~6~~5) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through Oregon Health Plan (OHP) fee-for-service, based on permanent residency.¶
(4~~7~~6) "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).¶
(4~~8~~7) "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).¶
(4~~9~~8) "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).¶
(~~50~~49) "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.¶
(5~~1~~0) "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.¶
(5~~2~~1) "Legal Holiday" means the days described in ORS 187.010 and 187.020.¶
(5~~3~~2) "Licensed Health Entity" means a Managed Care Entity (MCE) that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.¶
(54~~3~~) "Local Mental Health Authority" means one of the following entities:¶
(a) The board of county commissioners of one or more counties that establishes or operates a community mental health program;¶
(b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or¶
(c) A regional local mental health authority comprising two or more boards of county commissioners.¶
(54) "Local Planning Committee" means a local planning committee for alcohol and drug prevention and treatment services appointed or designated by the county governing body under ORS 430.342.¶
(55) "Managed Care Entity (MCE)" is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
(5~~5~~6) "Managed Care Organization (MCO)" is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.¶
(5~~6~~7) "Material Change to Delivery System" means:¶
(a) Any change to the CCO's Delivery System Network (DSN) that may result in more than five (5) percent of either its total Members or its Members in a county changing the physical location(s) of where services are received; or¶
(b) Any change to CCO's DSN that may likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type within the overall Provider Network or is the

sole provider specialty type with a practice within a county in the CCO's service area; or¶
(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or¶
(d) Any combination of the above changes.¶
(5~~7~~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.¶
(5~~8~~9) "Member" ~~means an Oregon Health Plan (OHP) client enrolled with a CCO~~has the meaning provided for in OAR 410-120-0000.¶
(~~59~~60) "Member Representative" means an individual who can make Oregon Health Plan (OHP)-related decisions for a member who is not able to make such decisions themselves.¶
(6~~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.¶
(6~~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.¶
(6~~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.¶
(6~~3~~4) "Oral Health" has the meaning provided for in OAR 410-123-1060.¶
(64~~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.¶
(6~~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 414.570.¶
(6~~6~~7) "Participating Provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(6~~7~~8) "Patient-Centered Primary Care Home (PCPCH)" means a recognized clinic that takes a patient and family-centered approach to all aspects of care. PCPCHs work with the member and their health care team to improve and coordinate care and help to eliminate repetitive procedures. As defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040 and means the definition as set forth in OAR 409-055-0010.¶
(6~~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.¶
(~~69~~70) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶
(a) CCOA: Physical, dental, and behavioral health services are paid by the client's CCO;¶
(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Dental services are paid the fee-for-service program;¶
(c) CCOE: Behavioral health services are paid by the client's CCO. Physical health and dental services are paid by the fee-for-service program;¶
(d) CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter ~~1~~410, division 120. Any reference to CCOF means the benefit package covers dental services only; and¶
(e) CCOG: Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.¶

(70<u>1</u>) "Post Hospital Extended Care Services" (PHECS). Consistent with 42 USC § 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than three (3) consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility:¶
(a) Within thirty (30) days after discharge from such hospital; or¶
(b) Within such time as it may be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care may not be medically appropriate within thirty (30) days after discharge from a hospital; and¶
(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within thirty (30) days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.¶
(71<u>2</u>) "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.¶
(72<u>3</u>) "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 associate 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 409-055-0010 and OAR 410-120-0000.¶
(73<u>4</u>) "Provider" means an individual, facility, institution, corporate entity, or other organization that:¶
(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or¶
(b) Bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a Provider, (and also termed a "Billing Provider"); and¶
(c) Supplies health services or items (also termed a "Rendering Provider").¶
(74<u>5</u>) "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~~<u>the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.2 Levels A and AA, and successor versions. This fulfills digital accessibility requirements under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) Title II</u>.¶
(75<u>6</u>) "Risk" in the context of Care Coordination is the combination of a Member's health needs based on their physical, development, behavioral, oral, and social health status (including Health Related Social Needs and Social Determinants of Health and Equity) that creates an increased chance of having a negative health outcome that could be prevented by effective Care Coordination that addresses those needs.¶
(76<u>7</u>) "Rising Risk" means health related circumstance changes or events a Member may experience as described in OAR 410-141-3865, that are likely to increase risk level or negatively impact their physical, developmental, behavioral, oral or social needs (including Health Related Social Needs and Social Determinants of Health and Equity) or wellbeing from a previously identified or existing level of risk.¶
(77<u>8</u>) "Risk Stratification" means the process by which CCOs employ continuous data feeds, analysis, application of appropriate clinical or practical subjectivity and other factors to score a ~~M~~<u>m</u>ember's identified physical, behavioral, developmental, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) and assign an appropriate risk level. Risk Stratification informs the level at which the CCOs coordinated services and activities (e.g., assessments, appropriate care planning, referrals) are deployed to meet the Member's needs.¶
(78<u>9</u>) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.¶
(~~79~~<u>80</u>) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:¶
(a) An infant, 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 infant, 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 three (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 four (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 one (1) year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than one (1) year.¶
(8~~0~~1) Social Determinants of Health and Equity (SDOH-E) has the meaning provided for in OAR 410-141-3735.¶
(8~~1~~2) "Special Health Care Needs" has the meaning provided for in OAR 410-120-0000.¶
(8~~2~~3) "Subcontract" means either:¶
(a) A contract between a CCO and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the CCO 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.¶
(8~~3~~4) "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. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.¶
(84~~5~~) "Transition of Care" applies to Medicaid members who are enrolled in a CCO ("the receiving CCO") immediately after disenrollment from a "predecessor plan" which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). Transition of Care does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan. Meets the standards pursuant to OAR 410-141-3850."¶
(8~~5~~6) "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.¶
(8~~6~~7) "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.¶
(8~~7~~8) "Trauma-informed services" means those services provided using a Trauma Informed Approach.¶
(8~~8~~9) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that shall 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.¶
(~~8~~90) "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.¶
(9~~0~~1) "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, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3505

RULE SUMMARY: Revise in accordance with HB 2211.

CHANGES TO RULE:

410-141-3505
Use of Subcontractors
(1) MCEs may delegate their activities or obligations to subcontractors except as otherwise provided by law or in the MCE contract:¶
(a) MCEs remain fully accountable for the performance of all subcontracted work, including that of all downstream entities contracted by MCE's subcontractor;¶
(b) MCEs shall monitor subcontractor performance on an ongoing basis;¶
(c) MCEs shall notify the Authority of subcontractor relationships. MCEs shall provide the Authority:¶
(A) A comprehensive list of subcontractor and downstream entities and, for each one, the activities and functions that have been delegated, to be submitted to OHA on an annual basis;¶
(B) Copies of all subcontracts upon request; and¶
(C) Adequate documentation demonstrating monitoring of subcontractor compliance or subcontractor auditing, as applicable, in accordance with the contract and with CMS requirements including 42 C.F.R §§ 438.230, 438.602(a) and 438.66.¶
(2) Each subcontract must include the following elements:¶
(a) With respect to any MCE activities or obligations defined by law or in the MCE's contract with the Authority that the MCE is delegating to a subcontractor:¶
(A) The subcontract must specify the delegated activities or obligations, as well as any related reporting responsibilities;¶
(B) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations; and¶
(C) The subcontract must either provide for revocation of the delegation or specify other remedies in instances where the Authority or the MCE determines that the subcontractor has not performed satisfactorily.¶
(b) The subcontractor agrees to comply with all applicable ~~laws, regulations,~~state and federal statutes, rules, regulations, executive orders and sub-regulatory guidance, as well as ~~th~~any and all other applicable requirements in the MCE contract:¶
(A) The subcontractor agrees to comply with Section C Part 10 of Attachment ~~I~~D of the 20~~17~~22-202~~2~~7 Medicaid 1115 Waiver regarding timely Payment to IHCP Providers;¶
(B) Timely payments means that IHCPs must be paid the agreed upon rate within 30-90 calendar days of billing;¶
(~~C~~c) The subcontractor agrees to perform any activities necessary to support the MCE and the Authority's obligations as specified in the MCE contract, state ~~law,~~ and federal ~~law, including~~statutes, rules, regulations, and sub-regulatory guidance.¶
(A) This includes, but is not limited to, requirements related to:¶
(i) Program integrity and data submission, including the requirements in 42 CFR, Part 438, Subpart H~~.~~;¶
(ii) Grievances and appeals, including the requirements in 42 CFR, Part 438, Subpart F;¶
(iii) Exclusions, as noted in 42 CFR § 438.808; and¶
(iv) Linguistic and disability access for members, as outlined in 42 CFR § 438.10, as well as 42 U.S.C. § 18116 and 45 CFR Part 92.¶
(B) Any other activities that may be required under state and federal statutes, rules, regulations, and sub-regulatory guidance.¶
(3) In addition to all of the requirements set out in section (2) above of this rule, an MCE subcontract with a dental subcontractor must also include the following terms and conditions:¶
(a) Clearly define the activities the MCE is delegating to the dental subcontractor, including activities related to the provision of Covered Services and to the dental subcontractor's fitness to enter into a subcontract under state and federal law and rule;¶
(b) Require a dental subcontractor to provide any and all reports, documents, or other information, or any combination thereof, that the MCE is required to provide under its contract with OHA, under this OAR chapter 410, and as may be additionally required under state and federal statutes, rules, regulations, executive orders and sub-regulatory guidance; and¶
(c) Dental subcontractor must agree to the delegated activities, related requirements and the associated compensation through a signed agreement before MCE can include dental subcontractor on its list of subcontractors to be submitted to OHA.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3510

RULE SUMMARY: Extend allowable period for recredentialing to include any partial month beyond the 3-year period.

CHANGES TO RULE:

410-141-3510
Provider Contracting and Credentialing
(1) Managed Care Entity's (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 (3) years.~~as follows:¶
(A) If the provider is credentialed or recredentialed on the 1st of a month, within three (3) years of that date; or¶
(B) If the provider is credentialed or recredentialed on a day other than the 1st of a month, within three (3) years from the 1st of the month that follows the month in which the provider was credentialed or recredentialed.¶
(b) 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~~c) 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 or the administration of the flu vaccine when administered in conjunction with the COVID-19 vaccination. 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) MCEs 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) MCEs may enroll COVID-19 vaccine administration providers who are included in the Authority's most recent active file of vaccine administration providers.¶
(C) MCEs shall monitor changes in the Authority's weekly active file of vaccine administration providers for terminations and changes.¶
(~~c~~d) MCEs shall screen their contracted HRSN Service Providers to be in compliance with 42 CFR §§ 455.410 through 455.436, 455.450, 455.452, and 455.470, and retain all resulting documentation for audit purposes.¶
(~~d~~e) MCEs may elect to contract for or delegate responsibility for the credentialing and screening processes; however, MCEs 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.¶
(~~e~~f) 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 contendere");¶
(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.¶
(~~f~~g) 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 may be excluded under 42

CFR 1001.101.¶
(~~g~~h) 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;¶
(~~h~~i) MCEs shall require each atypical provider to be enrolled with the Authority. MCEs shall also require each atypical provider, except HRSN Service Providers, unless that HRSN Service Provider is a licensed and credentialed professional authorized to bill Medicaid, to 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, except HRSN Service Providers, to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);¶
(~~i~~j) 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 (2)(b) of this rule 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 (2) 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 (2) and (3) 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.¶
(9) MCEs shall ensure that all contracted HRSN Service Providers meet the specific provider qualifications to provide HRSN Services to HRSN Authorized Members as described in OAR-410-120-2030.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.572, 414.665, 414.719, 414.632, 414.605

AMEND: 410-141-3525

RULE SUMMARY: Update to reflect “Flexible Services” as new name for “Health-Related Services”.

CHANGES TO RULE:

410-141-3525
Outcome and Quality Measures
(1) Managed Care Entities (MCEs) shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS.¶
(2) The MCE shall inform the Authority if it has been accredited by a private independent accrediting entity. If the MCE has been so accredited, the MCE shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review in accordance with CFR 42 CFR §438.332.¶
(3) As required by health system transformation, MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. Measures are selected by the Authority with the incentive measures specifically adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at the Metrics and Scoring Committee website located at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx.¶
(4) MCEs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health care, dental services, HRSN Services and all other health services provided by or under the responsibility of the MCE as specified in the MCE's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.¶
(5) MCEs shall implement an ongoing comprehensive quality assessment and performance improvement program (QAPI) for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the MCE's contract. This process shall include an internal Quality Improvement (QI) program with written criteria based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with the requirements set forth in 42 CFR §438.330, relevant law and the community standards for care, or in accordance with accepted medical practice, whichever is applicable, and with accepted professional standards. MCEs shall have in effect mechanisms to:¶
(a) Detect both underutilization and overutilization of services;¶
(b) Evaluate performance and customer satisfaction consistent with MCE contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);¶
(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3890 through 410-141-3915;¶
(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid funded long-term care or long-term services and supports benefits; or who are children receiving Child Welfare services or OYA services; and¶
(e) Report on the diversity and capacity of the workforce in their service area including capacity to provide services in a culturally responsive and trauma informed manner, appropriately relying on workforce data provided by the Authority;¶
(f) Undertake performance improvement projects that are designed to improve the access, quality and utilization of services. Projects must be designed to achieve significant improvement in health outcomes and member satisfaction.¶
(6) MCEs shall implement policies and procedures that assure the timely collection of data including health disparities and other data required by rule or contract (or both) that allows the MCE to conduct and report on its outcome and quality measures and report its performance. MCEs shall submit to the Authority the MCE's annual written evaluation of outcome and quality measures established for the MCE or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee; including but not limited to output from Electronic Health Records, Chart Reviews, Claim validation reports and other materials required for final assessment of relevant measures and within established deadlines.¶
(7) MCEs shall adopt practice guidelines consistent with 42 CFR § 438.236 and the MCE contract that addresses assigned contractual responsibilities for physical health care, behavioral health care, and/or dental services ; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3860; and concerns identified by members or their representatives and to implement changes that

have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.¶
(8) MCEs shall be accountable for both core and transformational measures of quality and outcomes:¶
(a) Core measures shall be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health). Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) Electronic Clinical Quality Measures (eCQM) and Healthcare Effectiveness Data and Information Set (HEDIS) that have state or national normative statistics;¶
(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational measures may include culturally informed care, health equity or ~~health-related services~~Flexible Services (per OAR 410-141-3845) not typically associated with medical care. Transformational metrics shall also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.¶
(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.372 and 442.373 and the MCE agreement in the manner authorized by OAR 409-025-0130.¶
(10) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. MCEs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The QI Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Authority members including those who are eligible for intensive care coordination (ICC) services under OAR 410-141-3870 or shall be able to retain consultation from individuals who are qualified.¶
(11) MCEs shall establish a QI Committee that shall meet at least every two months. The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:¶
(a) Approve the MCE annual quality strategy and retain oversight and accountability of quality efforts and activities performed by other MCE committees including the following: implementation of the annual quality strategy, a work plan that incorporates implementation of system improvements, and an internal utilization review oversight committee that monitors utilization against practice guidelines and Treatment Planning protocols and policies;¶
(b) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process, and review of results, progress, and effectiveness of corrective actions recommended at previous meetings. These records and minutes shall be made available to relevant Authority quality staff, upon request;¶
(c) MCEs shall conduct and submit to the Authority an annual written evaluation of the QI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the QAPI program and member care is to include an assessment of annual activities conducted which includes background and rationale, a plan of ongoing improvement activities to address gaps which shall ensure quality of care for MCE members and overall effectiveness of the QI program. MCEs shall submit their evaluations to the Authority contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy as outlined in the MCE contract for the QAPI and transformational care annual evaluation criteria;¶
(d) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant member complaints and appeals as required in OAR 410-141-3915;¶
(e) Review written procedures, protocols and criteria for member care no less than every two (2) years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3570

RULE SUMMARY: Remove exception for Health-Related/Flexible Services since they are not covered services.

CHANGES TO RULE:

410-141-3570
Managed Care Entity Encounter Claims Data Reporting
(1) MCEs shall meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Authority's 837 technical specifications for encounter data, and the Authority's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's website.¶
(2) MCEs shall collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the MCE must utilize the HIPAA standards:¶
(a) MCEs shall submit encounter claims for all covered services~~, except for health-related services,~~ provided to members as defined in OAR 410-120-0000 and 410-141-3500;¶
(b) MCEs shall submit encounter claims data including encounters for:¶
(A) Services where the MCE determined that liability exists, even if the MCE did not make any payment for a claim;¶
(B) Services where the MCE determined that no liability exists;¶
(C) Services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program;¶
(D) Paid amounts regardless of whether the servicing provider is paid on a fee-for-service (FFS) basis, on a capitated basis by the MCE, or the MCE's subcontractor; and¶
(E) Services to members who also have Medicare coverage, if a claim has been submitted to the MCE.¶
(c) MCEs shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare pursuant to 42 CFR 438.3(t);¶
(d) MCEs shall report encounter claims data whether the provider is an in-network participating or out-of-network, non-participating provider.¶
(3) MCEs shall follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.¶
(4) MCEs shall submit all valid unduplicated encounter claims for professional, dental, institutional, and pharmacy within 45 days of the date of adjudication:¶
(a) MCEs shall ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their website or by contacting the National Council for Prescription Drug Programs organization;¶
(b) Submission Standards and Data Availability:¶
(A) MCEs shall only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the MCE by the Authority in encounter claims:¶
(i) The National Provider Identifiers (NPI) for a provider covered entity enrolled with the Authority; or¶
(ii) The Oregon Medicaid proprietary provider numbers for the Authority enrolled non-covered atypical provider entities.¶
(B) MCEs shall make an adjustment to any encounter claim within 30 days of discovering the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed;¶
(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) of this section, the MCE must adjust or void the encounter claim within 30 days of notification by the Authority of the required action or as identified in paragraph (E) of this section;¶
(D) If the Authority discovers errors with a previously adjudicated encounter claim resulting from a federal or state mandate or request that requires the completeness and accuracy of the encounter data, the MCE must correct the errors within a timeframe specified by the Authority;¶
(E) If circumstances prevent the MCE from meeting requested timeframes for correction, the MCE may contact the Authority to determine an agreed upon specified date;¶
(F) MCEs retain liability for certifying encounter data as complete, truthful, and accurate. MCEs must ensure claims data received from providers, either directly or through a third-party submitter, is accurate, truthful, and complete by:¶
(i) Verifying accuracy and timeliness of reported data;¶
(ii) Screening data for completeness, logic, and consistency;¶
(iii) Submitting a complete and accurate Encounter Data Certification and Validation Report available on the Authority's website.¶

(G) MCEs shall make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.¶
(c) Encounter Claims Data Corrections for "must correct" Encounter Claims:¶
(A) The Authority shall notify the MCE of the status of all encounter claims processed;¶
(B) Notification of all encounter claims processed that are in a "must correct" status shall be provided by the Authority to the MCE each week and for each subsequent week the encounter claim remains in a "must correct" status;¶
(C) The Authority may notify the MCE of other errors; however, this information is also available in the MCE's electronic remittance advice supplied by the Authority;¶
(D) MCEs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the MCE notice that the encounter claim remains in a "must correct" status;¶
(E) MCEs Shall not delete encounter claims with a "must correct" status as specified in section (3)(d), except when the Authority has determined the encounter claim cannot be corrected or for other reasons.¶
(5) Electronic Health Records (EHR) Systems OAR 410-165-0000 to 410-165-0140. In support of an eligible provider's ability to demonstrate meaningful use as an EHR user, as described by 42 CFR 495.4 and 42 CFR 495.8, the MCE must:¶
(a) Submit encounter data in support of a qualified EHR user's meaningful use data report to the Authority for validation as set forth in OAR 410-165-0080;¶
(b) Respond within the timeframe determined by the Authority to any request for:¶
(A) Any suspected missing MCE encounter claims, or;¶
(B) MCE-submitted encounter claims found to be unmatched to an EHR user's meaningful use report.¶
(6) MCEs shall comply with the following hysterectomy and sterilization standards as described in 42 CFR 441.250 to 441.259 and the requirements of OAR 410-130-0580:¶
(a) MCEs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of claims adjudication as defined in OAR 410-141-3500; or immediately upon notification by the Authority that a qualifying encounter claim has been identified;¶
(b) The Authority in collaboration and cooperation with the MCE shall reconcile all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:¶
(A) Confirming the validity of the consent and notifying the MCE that no further action is needed;¶
(B) Requesting a corrected informed consent form; or¶
(C) Informing the MCE, the informed consent is missing or invalid and the payment must be recouped, and the associated encounter claim must be changed to reflect no payment made for services within the timeframe set by the Authority.¶
(7) Upon request by the Authority, MCEs shall furnish information regarding rebates for any covered outpatient drug provided by the MCE as follows:¶
(a) The Authority is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8) as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) for any covered outpatient drug provided by the MCE, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;¶
(b) MCEs shall report prescription drug data as specified in section (3)(b) of this rule.¶
(8) Encounter Pharmacy Data Rebate Dispute Resolution as governed by SSA Section 1927 42 U.S.C. 1396r-8 and as required by OAR 410-121-0000 through 410-121-0625. When the Authority receives an Invoiced Rebate Dispute from a drug manufacturer, the Authority shall send the Invoiced Rebate Dispute to the MCE for review and resolution within 15 days of receipt:¶
(a) The MCE shall assist in the dispute process as follows:¶
(A) By notifying the Authority that the MCE agrees an error has been made; and¶
(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 days of receipt of the Invoiced Rebate Dispute.¶
(b) If the MCE disagrees with the Invoiced Rebate Dispute that an error has been made, the MCE shall send the details of the disagreement to the Authority's encounter data liaison within 45 days of receipt of the Invoiced Rebate Dispute.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3575

RULE SUMMARY: Change “Readily Accessible” definition to refer to that in 410-141-3500.

CHANGES TO RULE:

410-141-3575
MCE Member Relations: Marketing
(1) The following definitions apply for purposes of OAR 410-141-3575 through 410-141-3585:¶
(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. This term includes, at a minimum, the types of alternate formats defined under the Americans with Disabilities Act (ADA) and 45 CFR Part 92, and shall include: braille, large (18 point) print, audio narration, oral presentation, electronic file, sign language interpretation, and sighted guide;¶
(b) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the MCE;¶
(c) "Marketing" means any communication from an MCE to a potential member who is not enrolled in the MCE that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE;¶
(d) "Marketing Materials" means materials that are produced in any medium by or on behalf of an MCE and that can reasonably be interpreted as intended to market to potential members;¶
(e) "Outreach" means any communication from an MCE to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the MCE's subcontractors and partners, and the MCE contractually required programs and services; and the promotion of healthful behaviors, health education and health related events. For full benefit dual eligible (FBDE) members, outreach to provide information about opportunity to align Medicare and Medicaid benefits, or CMS approved Default or Simplified enrollment for newly Medicare eligible member in the CCO regarding MA or DSNP, is allowable subject to OHA or CMS materials review.¶
(f) "Outreach Materials" means materials that are produced in any medium, by or on behalf of an MCE that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE;¶
(g) "Potential Member" means, as defined in OAR 410-141-3500, a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE;¶
(h) "Prevalent Non-English Language" means all non-English languages that are identified during the eligibility process as the preferred written language by the lesser of:¶
(A) Five percent of the MCE's total OHP enrollment; or¶
(B) One thousand of the MCE's members;¶
(i) "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~~has the meaning provided for in OAR 410-141-3500.¶
(j) "Written Member Materials" means informational and educational communications for members or potential members that are produced by or on behalf of an MCE in any written medium, including but not limited to: letters, brochures, guides, scripts, email, and text messaging. All written member materials must comply with the Authority's formatting and readability standards, as described in OAR 410-141-3585 and 42 CFR § 438.10, and be written in plain language sufficiently clear that a layperson could understand the information.¶
(2) MCEs shall comply with 42 CFR §§ 438.10, 438.100 and 438.104 to ensure that before enrolling OHP clients, the MCE provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that MCE. MCEs shall distribute the materials to its entire service area as indicated in its MCE contract. The MCEs may not:¶
(a) Distribute any marketing materials without first obtaining state approval;¶
(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and¶
(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.¶
(3) The following outreach to members or potential members are expressly permitted:¶
(a) The creation of name recognition by an MCE. Permissible methods for creating name recognition include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill-boards, web banners, health fairs, or health-related events;¶
(b) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors, so long as the communications do not constitute an attempt to compel or entice a client's enrollment;¶
(c) The following communications related to full benefit dual-eligible (FBDE) members with affiliated or

contracted MA or DSNP plans, and member's Medicare and Medicaid providers, as long as they do not constitute an attempt by the MCE to influence client enrollment:¶
(A) Communications to notify full benefit dual-eligible (FBDE) members of opportunities to align MCE-provided benefits with Medicare Advantage or Special Needs Plans or access ICC services;¶
(i) Provision of information about CCO's affiliated Medicare Advantage Plan or Dual Special Needs Plan, contact information to inquire about the plan or provider network, and opt-in enrollment form;¶
(ii) Provision of aligned Medicare Advantage or Dual Special Needs Plan Simplified or Default enrollment letters, and CMS approved communication materials for newly eligible members.¶
(B) Improving coordination of care through mechanisms such as referral to LTSS assessment with ODHS or providers of Home and Community Based Services, interdisciplinary care conferences, and use of HIE and event notifications;¶
(C) Communicating with providers serving full benefit dual-eligible (FBDE) members about unique care coordination needs or member needs such as ICC services, service authorizations, goals to ensure preventive screenings and assessments are scheduled as recommended, auxiliary aids and services or interpreter services; or¶
(D) Streamlining communications to the full benefit dual eligible (FBDE) member to improve coordination of benefits including provision of integrated member materials, i.e. handbooks, provider directories, summary of Medicare-Medicaid benefits, and ID cards for members with aligned MA or DSNP and CCO enrollment.¶
(4) MCEs shall update plan access information with the Authority on a monthly basis for use in updating the Authority's availability charts. The Authority shall confirm information before posting availability charts.¶
(5) MCEs and when applicable, the aligned Medicare Advantage or Dual Special Needs Plan have sole accountability for producing or distributing materials following Authority approval.¶
(6) MCEs shall comply with the Authority's marketing materials guidelines or other requirements for the submission, approval, review and correction of marketing materials or other communications with members or potential members. MCEs shall participate, as required, in development of guidelines or other requirements with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:¶
(a) A list of communication or outreach materials subject to review by the Authority;¶
(b) A clear explanation of the Authority's process for review and approval of marketing materials;¶
(c) A marketing materials submission form to ensure compliance with MCE marketing rules; and¶
(d) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3591

RULE SUMMARY: Clarify language regarding provision of member materials in a readily accessible manner.

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) A fee for access to the documentation;¶
(B) A requirement to receive a copy of the material via email;¶
(C) A requirement to register or create an account to receive the documentation; or¶
(D) 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 Federal Regulation § 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:¶
(A) 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;¶
(B) The software components and configurations that an application must use in order to successfully interact with the API and process its response(s); and¶
(C) 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 ~~a~~an reas~~d~~ily accessible ~~location~~manner 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 Federal Regulation §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.¶
(9) MCEs shall provide a process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213 and identified in the United States Core Data for Interoperability (USCDI):¶
(a) Such information received by the MCE shall be incorporated into the MCE's records about the current member;¶
(b) Upon approval and at the direction of a current or former member or their personal representative, the MCE shall:¶
(A) Receive all such data for a current member from any other payer obligated to provide it under federal regulations, that has provided coverage to the enrollee within the preceding 5 years;¶
(B) At any time the member is currently enrolled in the MCE and up to 5 years after disenrollment, send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data; and¶
(C) Send data received from another payer obligated to provide it under federal regulations, in the electronic form and format it was received.¶
(c) MCEs shall comply with the requirements of this section with regard to data they maintain with a date of service on or after January 1, 2016.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3700

RULE SUMMARY: Specify the request for application must be posted to OHA website in a readily accessible manner. Specify that OHA may only grant shorter contracts to potentially eligible applicants as all standard new CCO contracts and contract extensions must be the same length per HB 2205. Other miscellaneous updates and clarifications.

CHANGES TO RULE:

410-141-3700
CCO Application and Contracting Procedures
(1) The Authority shall establish an application process for entities seeking contracts as CCOs, in conformity with this OAR 410-141-3700 and OAR 410-141-3705. The following definitions apply with respect to that application process:¶
(a) "Applicant" means the entity submitting an application to be a CCO, or to enter into or amend a contract for coordinated care services;¶
(b) "Application" means an applicant's written response to a Request for Applications;¶
(c) "Request for Applications (RFA)" means the document used for soliciting applications for a CCO, award of or amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.¶
(2) The Authority shall use the following RFA processes for CCO procurement and contracting:¶
(a) The Authority shall provide public notice of every RFA on its website in a readily accessible manner. The RFA shall indicate how prospective applicants are made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;¶
(b) The RFA process shall begin with a public notice that shall be communicated using the Oregon ~~Procurement Information Network (ORPIN) websi~~Buys website, or a successor website utilized by the state. A public notice of an RFA shall identify the services the Authority is seeking, the designated service areas where services are requested, ~~a~~ sample contracts, and how potential applicants can keep informed of RFA updates;¶
(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;¶
(d) The RFA may request applicants to appear at a public meeting to provide information about the application;¶
(e) The RFA shall include, at a minimum, the elements required under OAR 410-141-3705, and shall request information from applicants to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;¶
(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require electronic submission of the application in accordance with OAR 137-047-0330, Electronic Procurements. If an electronic procurement process is used, applications shall be accepted only from applicants who accept the terms and conditions of the electronic method being used for application submission.¶
(3) Readiness Reviews:¶
(a) The Authority shall have discretion whether to have a readiness review process unless otherwise required by law and require successful completion of the readiness review as a condition to contracting;¶
(b) If the Authority chooses to have a readiness review process and require successful completion as a condition to contracting, the process shall be described in the underlying procurement document or otherwise communicated to respondents during the procurement process;¶
(c) Readiness review shall include those areas required by law and may also include other topics identified by the Authority;¶
(d) The Authority reserves the right to request to provide updated information gleaned during the readiness review process throughout the term of the resulting contract(s) as needed for compliance monitoring and performance reviews.¶
(4) The Authority shall determine that organizations meet the criteria for being CCOs as follows:¶
(a) The Authority shall issue CCO contracts only to applicants that meet the criteria in OAR 410-141-3705, meet the RFA requirements, and provide the assurances specified in the RFA. The Authority shall determine if the applicant qualifies for being a CCO based on the application and any additional information and investigation that the Authority may require;¶
(b) The Authority shall notify each applicant that applies for CCO status if it meets the criteria for being a CCO;¶
(c) In selecting one or more CCOs to serve a geographic area, the Authority shall:¶

(A) For members and potential members, optimize access to care and choice of providers, and where possible choice among CCOs;¶
(B) For providers, optimize choice in contracting with CCOs; and¶
(C) Allow more than one CCO to serve the geographic area if desirable to optimize access and choice under this subsection.¶
(d) The Authority may determine that an applicant is potentially eligible for a CCO contract in accordance with paragraph (f) below. The Authority is not obligated to determine whether an applicant is potentially eligible for a CCO contract if, in its discretion, the Authority determines that sufficient applicants eligible for a CCO contract are available to attain the Authority's objectives under the RFA;¶
(e) The Authority may determine that an applicant is potentially eligible for a CCO contract if:¶
(A) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period; and¶
(B) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for a CCO contract. The Authority shall determine the date and required documentation and written assurances required from the applicant;¶
(C) If the Authority determines that an applicant potentially eligible for a CCO contract does not meet the criteria for a CCO contract within the time announced in the RFA for contract award, the Authority may:¶
(i) Offer a CCO contract at a future date ~~when the applicant demonstrates~~to a potentially eligible CCO that the Authority identified during the same period it made the determination for all other applicants (as described in subsections (a) - (c) and (f) of this section (4) of this rule) to a specific RFA. The offer of a CCO contract at a future date that is permitted under this rule shall be subject to the potentially eligible CCO applicant demonstrating to the Authority's satisfaction that the applicant is eligible for a CCO contract within the scope of and subject to the requirements of the RFA; or¶
(ii) Inform the applicant that it is not eligible for a CCO contract.¶
(f) The Authority shall enter into a new contract(s) or contract renewal with a CCO only if the CCO meets the criteria for being a CCO and the Authority determines that the contract(s) would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes but is not limited to:¶
(A) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda; and¶
(B) The number of CCOs in the region.¶
(5) The application is the applicant's offer to enter into a contract(s) and is a firm offer for the period specified in the RFA. The Authority's award of the contract(s) constitutes acceptance of the offer and binds the applicant to the contract:¶
(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;¶
(b) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;¶
(c) The Authority may award multiple contracts or make a single award or limited number of awards to meet the Authority's needs, including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA; and¶
(d) Subject to any limitations in the RFA, the Authority may execute a contract renewal for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA.¶
(6) Disclosure of application contents and release of information:¶
(a) Except for the letter of intent to apply, information may not be disclosed to any applicant or the public until the award date, unless otherwise specified in the RFA and allowed by law. The "award date" refers to the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts. No information may be given to any applicant or the public relative to its standing with other applicants before the award date except under the following circumstances:¶
(A) The information in the application may be shared with the Authority, DCBS, Oregon Health Insurance Marketplace, PEBB, OEBB, PERS, CMS, and those individuals involved in the application review and evaluation process; and¶
(B) Information may be provided by the applicant to the public as part of a public review process.¶
(b) Application information may be disclosed on the award date, except for information that has been clearly identified and labeled confidential in the manner specified in the RFA if the Authority determines it meets the disclosure exemption requirements.¶
(7) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements

in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts funded by federal funds.¶
(8) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on June 30, 2018) to govern RFAs and contracting with CCOs:¶
(a) General Provisions Related to Public Contracting: OARs 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;¶
(b) Public Procurements for Goods or Services: OARs 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and 137-047-0800;¶
(c) In applying the DOJ Model Rules to RFAs under this rule:¶
(A) An application is a proposal under the DOJ Model Rules;¶
(B) An RFA is an RFP under the DOJ Model Rules;¶
(C) Certification as a CCO is pre-qualification under the DOJ Model Rules if the Authority requires certification as a condition to contract;¶
(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are incorporated herein;¶
(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.¶
(9) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.
Statutory/Other Authority: ORS 414.615, 414.625, 414.635, 414.651, 413.042
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3715

RULE SUMMARY: Change dental care organization reference to dental subcontractor.

CHANGES TO RULE:

410-141-3715
CCO Governance; Public Meetings and Transparency
(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council (CAC) that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws. ¶
(2) Consumer Representative means a person serving on a CAC who is currently or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian, or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.-¶
(3) Each CCO's governing body must include:¶
(a) At least one member representing persons that share in the financial risk of the organization;¶
(b) A representative of a dental ~~care organization~~subcontractor selected by the coordinated care organization;¶
(c) The major components of the health care delivery system;¶
(d) At least two health care providers in active practice, including:¶
(A) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and¶
(B) A mental health or chemical dependency treatment provider.¶
(e) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and¶
(f) At least two members of the CAC:¶
(A) At least one of the CAC representatives on the CCO's governing body must be a current CAC Consumer Representative;¶
(B) CAC members of the governing body shall have full voting rights.¶
(4) For purposes of the open meetings requirement in Section 2 of Enrolled 2018 HB 4018, 2018 Oregon Laws Chapter 49, "substantive decision" means a decision made by the governing board of a coordinated care organization (CCO) that relates to:¶
(a) Spending of public funds;¶
(b) The financial risk of the CCO;¶
(c) Provider network development and capacity; or¶
(d) The community advisory council, community health assessment, or community health improvement plan.¶
(5) Substantive decision does not require or include:¶
(a) Disclosure of trade secrets as defined in ORS 192.345;¶
(b) Confidential communications with a lawyer that are privileged under ORS 40.225;¶
(c) Information of a personal nature as described in ORS 192.355;¶
(d) Protected health information as defined in ORS 192.556;¶
(e) Names of Oregon Health Plan consumer members of a community advisory council who request to remain anonymous;¶
(f) Confidential human resource matters; or¶
(g) Provider credentialing, sanctioning, or termination.¶
(6) The term "substantive decision" excludes immaterial technical decisions.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625
Statutes/Other Implemented: Oregon Laws 2018 Chapter 49

AMEND: 410-141-3730

RULE SUMMARY: Include that a CCO must also collaborate with community mental health programs and local planning committees in developing a shared Community Health Assessment (CHA) and a Community Health Improvement Plan (CHP) per HB 2208.

CHANGES TO RULE:

410-141-3730
Community Health Assessment and Community Health Improvement Plans
(1) CCOs shall comply with the requirements in ORS 414.~~62~~575, 414.577 and 414.~~629~~578, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, community mental health programs, local planning committees, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.¶
(2) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.¶
(3) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:¶
(a) County and city government representatives;¶
(b) Federally recognized tribes (if not already collaborating on a shared CHA);¶
(c) SDOH-E partners, as defined in OAR 410-141-3735;¶
(d) Local mental health authorities ~~and community mental health programs~~;¶
(e) Physical, behavioral, and oral health care providers;¶
(f) Federally Qualified Health Centers;¶
(g) Indian Health Care Providers;¶
(h) Traditional Health Workers;¶
(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;¶
(j) Culturally specific organizations, including Regional Health Equity Coalitions; and¶
(k) Representatives from populations who are experiencing health and health care disparities.¶
(4) The CHA must include or identify and analyze at a minimum, all of the following:¶
(a) The demographics of all of the Communities within Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, sex, gender identity, and sexual orientation. CCOs shall work with community organizations and available data sources to obtain information on gender identity and sexual orientation if it is available;¶
(b) The health status and issues of all the Communities within Contractor's Service Area;¶
(c) The health disparities among all of the Communities within Contractor's Service Area;¶
(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;¶
(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);¶
(f) Assets and resources that can be utilized to improve the health of ~~the~~ all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:¶
(A) Access to primary prevention resources;¶
(B) Disproportionate, unmet, health-related needs;¶
(C) Description of assets within the Community that can be built on to improve the Community's health;¶
(D) Systems of seamless continuum of care; and¶
(E) Systems or programs of collaborative governance of community benefit.¶
(g) Means to promote the health and early intervention in the treatment of children and adolescents within Contractor's Service Area, and whether they are sufficient and effective;¶
(h) Areas for improvement; and¶
(i) The persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.¶

(5) CCOs and their CACs must develop baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, neighborhood and environment, or other factors. This data will be used to identify and prioritize strategies to reduce health disparities in the development of their CHPs.¶
(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).¶
(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP. The CCOs' CACs are responsible for adopting CHPs.¶
(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:¶
(a) County and city government representatives;¶
(b) Federally recognized tribes (if not already collaborating on a shared CHA);¶
(c) SDOH-E partners, as defined in OAR 410-141-3735;¶
(d) Local mental health authorities ~~and community mental health programs~~;¶
(e) Physical, behavioral, and oral health care providers;¶
(f) Federally Qualified Health Centers;¶
(g) Indian Health Care Providers;¶
(h) Traditional Health Workers;¶
(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;¶
(j) Culturally specific organizations, including Regional Health Equity Coalitions; and¶
(k) Representatives from populations who are experiencing health and health care disparities.¶
(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.¶
(a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:¶
(A) Closing the gap on disproportionate, unmet, health-related needs;¶
(B) Creating access to primary prevention;¶
(C) Building a system of seamless continuum of care;¶
(D) Building on current Community resources and improving Community capacity to improve health or address SDOH-E, or both; and¶
(E) Engaging the Community in the implementation of the CHP.¶
(b) The CHP strategies should be based on research and may include, without limitation:¶
(A) Developing ~~a~~ or supporting Health Policy that supports the CHP goals and objectives;¶
(B) Implementing or supporting community health or SDOH-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;¶
(C) Developing public and private resources and capacities;¶
(D) Designing and building a system of Integrated service delivery;¶
(E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.¶
(c) The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies;¶
(d) The CHP must also address, with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the needs of adolescents and children in a CCO's Service Area and must address:¶
(A) Findings based on research, including adverse childhood experiences;¶
(B) The adequacy of existing school-based health center (SBHC) networks and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community;¶
(C) The integration of all services provided to meet the needs of children, adolescents, and families; and¶
(D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.¶
(10) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and improving health equity. Progress reports

will be submitted in the manner and form proscribed by OHA.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3735

RULE SUMMARY: Clarify language on categorization of SHARE expenses under federal regulations.

CHANGES TO RULE:

410-141-3735
Social Determinants of Health and Equity; Health Equity
(1) This rule defines health disparities and the Social Determinants Of Health and Equity (SDOH-E), establishes requirements for Supporting Health for All through Reinvestment (SHARE), establishes the role of the Community Advisory Councils in supporting SDOH-E, establishes requirements for collecting data on race, ethnicity, and primary language, and establishes requirements for developing health equity infrastructure within a Coordinated Care Organization (CCO). This rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.¶
(2) The following definitions apply for purposes of this rule:¶
(a) "Adjusted Net Income" is the pre-tax net income reported by a CCO for a calendar year (or a partial year, if relevant) pursuant to OAR 410-141-5015, adjusted by the Authority pursuant to section 3(a)(E) of this rule for items such as the following:¶
(A) Excessive administrative expenses, including management bonuses;¶
(B) Improper allocation of expenses across lines of businesses;¶
(C) Non-operating revenues and expenses;¶
(D) Adjustments to base data made as part of the capitation rate development;¶
(E) Expenses not supported by legitimate business purposes;¶
(F) Payments or transfers to subcontractors, parent companies, affiliates, or subsidiaries.¶
(b) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, the CCO;¶
(c) "Capitated Affiliate" means a CCO's capitated subcontractor, as defined in OAR 410-141-5000, that is an affiliate of the CCO;¶
(d) "Control" means possessing the direct or indirect power to manage a person or set the person's policies, whether by owning voting securities, by contract other than a commercial contract for goods or nonmanagement services, by representation on the person's board, or otherwise, unless the power is the result of an official position or corporate office the person holds;¶
(e) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the indicators used to track progress toward achieving health equity;¶
(f) "Social Determinants of Health and Equity" (SDOH-E):¶
(A) SDOH-E encompasses three terms:¶
(i) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities;¶
(ii) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities;¶
(iii) Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.¶
(B) SDOH-E initiatives may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:¶
(i) Community-level interventions that directly address social determinants of health or social determinants of equity;¶
(ii) Interventions to address individual health-related social needs.¶
(g) "SDOH-E Partner" is a single organization, local government, one or more of the Federally-recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area.¶
(3) The following requirements are specific to Supporting Health for All through Reinvestment (SHARE):¶
(a) For each calendar year starting on or after January 1, 2023, CCOs shall dedicate a portion of their previous calendar year's adjusted net income or reserves to SDOH-E spending, pursuant to ORS 414.572(1)(b)(C) and as set forth in the contract:¶
(A) The portion of adjusted net income or reserves spent shall equal or exceed the greater of:¶

(i) A percentage of average adjusted net income for the prior three calendar years on a sliding scale based on Contractor's Risk Based Capital (RBC) percentage as of the end of the most recent calendar year (but prior to the SHARE portion calculation); or¶
(ii) A proportion of the amount recorded in dividends or similar payments or both to shareholders, affiliates, or other owners in that prior year. For purposes of this section, these payments include adjusted net income earned by capitated affiliates. Capitated affiliates' adjusted net income is calculated as defined in section 2(a) of this rule, but with respect to the capitated affiliates' lines of business under the Contractor as reported to the Authority through Contractor's financial statements under OAR 410-141-5015. For purposes of this section, dividends or similar payments solely designated to satisfy tax obligations of affiliates that arise on account of serving the CCO's Oregon Health Plan members shall be excluded, provided that the CCO provides documentation which is approved by the Authority.¶
(B) The Authority will provide the specifications for (3)(A)(i) and (ii) of this rule, including the sliding scale to CCOs in SHARE Guidance, which is located here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/SHARE-Initiative-Guidance-Document.pdf;¶
(C) The value of the RBC% floor, for the purposes of the sliding scale, will be the greater of:¶
(i) 300% RBC; or¶
(ii) The percentage referenced in OAR 410-141-5180(2) in relation to dividend payment restrictions.¶
(D) A CCO may dedicate more than its required minimum SHARE obligation for a given calendar year, as calculated pursuant to the requirements of (3)(a)(A)(i) and (ii), to be used toward satisfying all or a portion of the following:¶
(i) The current year's SDOH-E spending requirement (e.g., excess SHARE designations reported to OHA in 2024 may be applied to a CCO's SHARE spending in 2025); and/or¶
(ii) Any of the SDOH-E requirements for the three calendar years' immediately following the date the excess SHARE designations were reported to OHA.¶
(E) The Authority may adjust net income under section 2(a) of this rule for the purpose of ensuring that CCOs do not calculate or distribute net income in a manner that effectively avoids or reduces SHARE spending. The Authority will present any adjustments made under this section via administrative notice to an affected CCO within 45 days of the due date for filing the financial reporting in which the SHARE obligation is determined. The notice will indicate the reasons for the adjustment and the amount of adjustment arising from each reason. The Authority will provide the CCO 30 days to reply in writing with objections or comments;¶
(F) The Authority may extend relief from minimum SHARE spending requirements in the event of net losses that would otherwise place the CCO's capital, surplus or reserves below 200% RBC.¶
(b) CCOs shall select SDOH-E spending priorities that fall into at least one of these five domains of SDOH-E: Neighborhood and Built Environment, Economic Stability, Education, Social and Community Health, and Health Care Access and Quality, and are consistent with:¶
(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in OAR 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs; and¶
(B) Any SDOH-E priority areas identified by the Authority.¶
(c) A portion of SHARE dollars must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract, a Memorandum of Understanding, or other form of agreement including a grant agreement, with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO;¶
(d) SHARE expenses ~~need not~~are not required to meet the requirements of 45 CFR 158.150(b)~~,~~ and are paid for with funding separate from premium revenue. Therefore, SHARE expenses do not ~~m~~neet~~d~~ ~~the requirements of health-related services or~~o be considered "activities that improve health care quality" under ~~CMS regulations~~45 CFR 158.150(b) and are not included in Medical Loss Ratio (MLR) as defined in 42 CFR 438.8;¶
(e) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.¶
(4) Community Advisory Councils (CAC):¶
(a) CCOs shall designate a role for the CAC in SHARE spending decisions;¶
(b) CCOs shall have a conflict of interest policy that applies to its CAC members and accounts for financial interests related to SHARE and other SDOH-E spending;¶
(c) CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues. These reports will be posted publicly with appropriate redactions.¶
(5) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing

basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.¶
(6) Health Equity Infrastructure:¶
(a) The term "Health equity infrastructure" refers to the adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to:¶
(A) Community and member engagement;¶
(B) Provision of quality language access;¶
(C) Workforce diversity;¶
(D) ADA compliance and accessibility of CCO and provider network;¶
(E) ACA 1557 compliance;¶
(F) CCO and provider network organizational training and development;¶
(G) Implementation of the CLAS Standards;¶
(H) Non-discrimination policies.¶
(b) The "Health Equity Plan" is part of the "Health Equity Infrastructure";¶
(c) CCOs shall:¶
(A) Develop and implement the "Health Equity Plan" to embed health equity as a value and business practice into organizational policies, procedures, and processes;¶
(B) Meet state and federal laws and contractual obligations regarding accessibility and culturally and linguistically responsive health care and services;¶
(C) Inform using an equity framework in all policy, operational, and budget decisions;¶
(D) Provide a structure to ensure oversight and management of programs and services with the goal to advance health equity and provide culturally and linguistically appropriate services.¶
(d) The Health Equity Plan shall include the following:¶
(A) Narrative of the Health Equity Plan development process, including description of meaningful community engagement;¶
(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics;¶
(C) Organizational and Provider Network Cultural Responsiveness and Implicit Bias training plan:¶
(i) CCO shall incorporate Cultural Responsiveness and implicit bias continuing education and training into its existing organization-wide training plan and programs;¶
(ii) CCO shall align cultural responsiveness and implicit bias trainings with the "Cultural Competence Continuing Education" criteria developed by the Authority's Cultural Competence Continuing Education Advisory Committee referenced in OAR 950-040-0020;¶
(iii) CCO shall adopt the definition of Cultural Competence set forth in OAR 950-040-0010;¶
(iv) CCO shall provide and require all its employees, including directors, executives, and CAC members to participate in all such trainings;¶
(v) CCO's shall require all CCO's Provider Network to comply with Cultural Competency Continuing Education requirements set forth in ORS 676.850.¶
(e) The Health Equity Plan and the language access self-assessment report are required to be submitted under OAR 410-141-3515 and shall be submitted every year to the Authority for review and approval;¶
(f) CCOs shall designate a Single Point of Accountability. The single point of accountability can also be called the Health Equity Administrator:¶
(A) The Single Point of Accountability ("Health Equity Administrator") shall be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network and CCO service area;¶
(B) The Single Point of Accountability ("Health Equity Administrator") shall have budgetary decision-making authority and health equity expertise;¶
(C) The Single Point of Accountability ("Health Equity Administrator") shall be a high-level employee (e.g., director level or above) and can have more than one area of responsibility and job title;¶
(D) The CCO shall inform and describe to the Authority any changes related to the "Health Equity Administrator" role or scope using the Health Equity Plan;¶
(E) The Single Point of Accountability ("Health Equity Administrator") shall have the authority to communicate directly with CCO executives and governing board.
Statutory/Other Authority: ORS 413.042, 414.575, 414.578, 414.591, 414.605
Statutes/Other Implemented: ORS 414.570 - 414.686

AMEND: 410-141-3810

RULE SUMMARY: Clarify direction on where CCOs are to submit disenrollment requests. Additional clarifying language for disenrollment proceedings in cases where the member is residing outside of service area or has committed fraudulent or illegal acts.

CHANGES TO RULE:

410-141-3810
Disenrollment from MCEs
(1) Member-initiated requests for disenrollment.¶
(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule;¶
(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:¶
(A) Without cause:¶
(i) Members may request to change their MCE enrollment within thirty (30) calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur on the next available enrollment date;¶
(ii) Members may request to change their MCE enrollment within ninety (90) calendar days of the initial MCE enrollment. If approved, the change would occur on the next available enrollment date;¶
(iii) Members may request to change their MCE enrollment after they have been enrolled with the MCE for at least six (6) months. If approved, the change would occur at the end of the month;¶
(iv) Members may request to change their MCE enrollment at their OHP eligibility renewal. If approved, the change would occur at the end of the month;¶
(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. If a request for disenrollment is approved under this section, the change would occur at the end of the month.¶
(B) With cause, at any time as follows:¶
(i) The member moves out of the MCE service area; or¶
(ii) Due to moral or religious objections the MCE does not cover the service the member seeks;¶
(iii) When the member needs related services (for example a Caesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.¶
(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to FFS at any time subject to the provisions set forth in OAR 410-141-3805(14)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition;¶
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include but are not limited to:¶
(i) The member is an American Indian or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the FFS delivery system;¶
(ii) The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member for a provider of a treatment, service, or supply:¶
(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary MCE exemption;¶
(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the

member's administrative hearing rights;¶
(E) If thirty (30) calendar days pass without a decision from the Authority on a member's disenrollment request, the request becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).¶
(c) A member may request a temporary enrollment exception during pregnancy as follows:¶
(A) A temporary enrollment request shall be granted if a member is at any point in the third trimester of pregnancy and:¶
(i) The member is newly determined eligible for OHP; or¶
(ii) The member is newly re-determined eligible for OHP and not enrolled in a MCE within the past three (3) months; or¶
(iii) The member is enrolled with a new MCE that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider.¶
(B) The enrollment exemption shall remain in place until sixty (60) calendar days postdate of either the delivery of the member's child or the pregnancy otherwise ends, at which time the member shall be enrolled in the appropriate MCE in their service area. Where there is a choice among multiple MCEs in the member's service area the member may choose an open plan; however, if the member does not express preference, the Authority shall auto assign on a next weekly basis.¶
(d) Upon approval of a member's disenrollment from a MCE, the member shall join another MCE unless:¶
(A) The member resides in a service area where enrollment is voluntary;¶
(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805;¶
(C) The member meets disenrollment criteria stated in this rule; or¶
(D) There is not another MCE available and open to new enrollment in the service area.¶
(2) MCE-initiated disenrollment requests for reasons other than fraudulent or illegal acts, uncooperative or disruptive behavior, or credible threats of violence: MCEs may request disenrollment for any of the ~~reasons in subsection (2)(a) of this rule~~following reasons. Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified ~~in this subsection (2)(a) of this rule~~. After review of all necessary documentation submitted with an MCE's request, the Authority shall grant such requests, except the Authority may deny requests based on the reason set forth in sub~~paragraph~~section (~~G~~g) below:¶
(a) If the individual is enrolled after the first day of admission to an inpatient setting, the enrollment shall be cancelled as never effective and the individual shall be enrolled in a MCE on the next available enrollment date following discharge from the continuous inpatient stay. This does not apply if the member is a newborn child born to an OHP eligible mother enrolled with a MCE at time of birth in accordance with OARs 410-141-3500 and 410-141-3805;¶
(b) If the MCE determines the member has Third Party Liability (TPL), the MCE shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The MCE shall receive an emailed tracking number following the online report. The MCE may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, the member shall be disenrolled from the MCE effective at the end of the month the TPL is reported, with the exception of:¶
(A) When Good Cause determination is active or concurrently documented, in which case the member shall retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(B) Some situations in which the Authority may approve retroactive disenrollment;¶
(C) When the client has dental TPR and is enrolled in the CCOF plan type.¶
(c) If a member has been residing outside the MCE's service area for more than three (3) months unless previously arranged with the MCE, and the member is unable to be reached or has not responded to MCE requests to contact the Authority to update their address. The MCE shall provide written documentation that the member has been residing outside its service area for more than three (3) months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR shall notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;¶
(d) If the member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal facility. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;¶
(e) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric

institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution;¶
(f) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the MCE;¶
(g) The member had End Stage Renal Disease at the time of enrollment in the MCE.¶
(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.¶
(a) MCEs have the right to request the Authority disenroll members from the MCE when they commit fraudulent or illegal acts related to participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts;¶
(b) The MCE shall report any illegal acts by an MCE member to law enforcement authorities and~~, if appropriate,~~ to the ODHS Fraud Investigations Unit;¶
(c) When requesting disenrollment based on an MCE member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, including any verification of reports submitted to law enforcement and~~, if applicable,~~ the ODHS Fraud Investigations Unit;¶
(d) Based on the evidence presented, the CCO AR shall review the disenrollment request and all submitted evidence with Authority staff. The review process shall be documented and a recommendation for disenrollment shall be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member from the MCE and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.¶
(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.¶
(a) Subject to applicable disability discrimination laws and section (4) of this rule, the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule;¶
(b) For purposes of this rule, a "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the MCE shall make an individualized assessment based on reasonable judgment that relies on:¶
(A) Current medical knowledge or the best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others;¶
(B) The probability that potential injury to others shall actually occur; and¶
(C) Whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others.¶
(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:¶
(A) Physical, intellectual, developmental, or mental disability; or¶
(B) An adverse change in the member's health; or¶
(C) Under or over-utilization of services; or¶
(D) Filing a grievance or exercising any appeal or contested case hearing rights; or¶
(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or¶
(F) Uncooperative or disruptive behavior resulting from the member's special needs.¶
(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member. The provider shall document the written notification to the MCE in the member's medical record;¶
(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:¶
(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider. The MCE shall document the education, training, and the resources or services furnished to the reporting provider;¶
(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:¶
(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;¶
(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and¶

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

(A) The notification may be made to the MCE by telephone provided that such notice is followed by written notice to the MCE;¶
(B) Notice under subsection (5)(c) of this rule shall describe the circumstances surrounding the act or credible threat of violence and the actions taken by the provider as a result;¶
(C) MCEs shall require their providers to document the incident in the member's medical record and the MCE shall document the provider's notice in the member's case file.¶
(d) The MCE shall notify the member's care team of the act or credible threat of violence. The MCE shall involve the member's care team and, within the laws governing confidentiality, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior;¶
(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence;¶
(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes listed in section (4) of this rule prior to making any request for disenrollment;¶
(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (5)(d) of this rule, by following the process set forth in section (4) of this rule, the MCE shall have the right to request the member's disenrollment. The MCE's disenrollment request shall comply with all of the requirements set forth in section (4)(g) of this rule and shall also comply with all additional requirements as follows:¶
(A) Include an explanation of why the MCE believes the exception to following the process explained in section (4) of this rule is necessary as it relates to an act of, or credible threat of, physical violence; and¶
(B) In addition to all other documentation required to be submitted under section (4) of this rule, the request must also include a copy of the police report or case number. If a police report or case number is not available, the MCE shall submit a copy of the provider's entry in the member's medical record, which must be signed by the provider, or a copy of the MCE's entry into the member's case file signed by the applicable MCE personnel, or both, that documents the report to law enforcement or any other reasonable evidence.¶
(6) Approval or Denials of MCE Requests for Disenrollment Due to Uncooperative or Disruptive Behavior, Acts of Violence, or Credible Threats of Violence.¶
(a) MCE requests made without all documentation, including CCO AR requests for additional or clarifying information, required under sections (4) and (5) of this rule shall be denied:¶
(A) When there is insufficient documentation submitted with a request for disenrollment, the CCO AR shall notify the MCE of the denial within two (2) business days of the initial request;¶
(B) MCEs may submit a new request for disenrollment once all required documentation is completed and available to be provided to the CCO AR.¶
(b) After receipt of a complete MCE request for disenrollment, the request shall be evaluated by the MCE's CCO AR and relevant subject matter experts, including those with licensure or certification, as well as expertise appropriate to the circumstances identified in the request for disenrollment (disenrollment review team);¶
(c) The CCO AR shall document the review, recommendations, and rational with relevant regulatory or clinical criteria made by the disenrollment review team:¶
(A) The CCO AR shall provide the documentation and recommendations made by the disenrollment review team to Authority's management for a decision regarding disenrollment of the affected member;¶
(B) The documentation provided to Authority management by the CCO AR shall also include the name of all disenrollment review team members, their respective areas of expertise, licensure or certification, or both;¶
(C) The decision, and all individuals involved in making the decision to approve or deny an MCE request for disenrollment under section (6) of this rule shall be documented in the affected member's case file maintained by the Authority.¶
(d) The CCO AR shall provide written notice on Authority letterhead to the MCE of the Authority's decision to approve or deny the MCE's request for disenrollment. The CCO AR shall provide copies of the notice to the MCE CEO, MCE COO, and the Authority Medicaid Director:¶
(A) All notices of disenrollment approvals and denials shall include the reason for the decision along with applicable, supporting regulatory or clinical criteria, or both, and identify the subject matter expertise and credentials of the disenrollment review team. However, the names of the individuals on the disenrollment review team shall not be included in the notice;¶
(B) When there is sufficient documentation for the CCO AR to convene a disenrollment review team, the notice of approval or disapproval of the request for disenrollment shall be made by the Authority within fifteen (15) business days of receipt of the request for disenrollment.¶
(e) The CCO AR shall provide the affected member with written notice of their disenrollment within five (5)

business days after the Authority has approved the MCE's request for disenrollment. A copy of the member notice shall be sent to the MCE, which the MCE shall distribute to the member's care team. A copy of the member notice shall be placed in the member's case file maintained by the Authority. The notice of disenrollment provided to the member shall include all of the following information:¶
(A) The disenrollment date;¶
(B) The reason for disenrollment;¶
(C) Information regarding the member's right to file a grievance and their administrative hearing rights; and¶
(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in the Authority's record of the request and provided to the MCE for distribution the member's care team.¶
(f) The date of disenrollment shall be effective ten calendar days after the date of the member's disenrollment notice, unless:¶
(A) The member files a grievance or otherwise requests a hearing, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon such decisions; or¶
(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE shall be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.¶
(7) Enrollment for Authority Approved Disenrollment.¶
(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or¶
(b) When circumstances permit, and there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or¶
(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR shall place an enrollment exemption for the appropriate MCE CCOA, CCOB, CCOE, CCOF, and CCOG plans and place the member on Open Card for a twelve (12) month period, after which the CCO AR shall reevaluate enrollment options for the member.¶
(8) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the MCE, all disenrollments are effective the end of the month the Authority approves the disenrollment:¶
(a) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority;¶
(b) If the member dies, the last date of enrollment shall be the date of the member's death.¶
(9) Transfers of 500 or more members.¶
(a) As specified in ORS 414.611, the Authority may approve the transfer of 500 or more members from one MCE to another MCE if:¶
(A) The member's provider has contracted with the receiving MCE and the provider has stopped accepting patients from the MCE from which the member is being transferred, or has terminated providing services to members who are enrolled with the MCE from which the member is being transferred;¶
(B) Members are offered the choice of remaining enrolled in the transferring MCE; and¶
(C) The member and all family (case) members shall be transferred to the provider's new MCE.¶
(b) The transfer shall become effective the date on which the provider's contract with their current MCE terminates or otherwise expires, or on another date approved by the Authority;¶
(c) Members shall not be transferred under section (9) of this rule unless the following conditions have been satisfied:¶
(A) The Authority has evaluated the receiving MCE and determined that the receiving MCE meets criteria established by the Authority as stated in OAR 410-141-3705 including, but not limited to, ensuring that the MCE maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and¶
(B) The Authority has provided notice of a transfer to members affected by the transfer at least ninety (90) calendar days before the scheduled date of the transfer.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065, ORS 414.727

AMEND: 410-141-3835

RULE SUMMARY: Change timeframe for processing standard PA requests from 14 days to 7 days. Include that PA decisions for complex rehab technology repairs are to be made within 72 hours per SB 549.

CHANGES TO RULE:

410-141-3835
MCE Service Authorization
(1) Coverage of services is outlined by MCE contract and Oregon Health Plan (OHP) benefits coverage in OAR 410-120-1210 and OAR 410-120-1160.¶
(2) A member may access urgent and emergency services 24 hours a day, seven (7) days a week without prior authorization.¶
(3) The MCE may not require a member to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. A member may self-refer to assessment, evaluation, and behavioral health services from the Provider Network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.¶
(4) A member may access the following outpatient behavioral health services from within the MCE's Provider Network, without Prior Authorization, including but not limited to:¶
(a) "Assertive Community Treatment" as defined in OAR 309-019-0105, "Enhanced Care Services" as defined in OAR 309-019-0105, "Enhanced Care Outreach Services" as defined in OAR 309-019-0105, "Wraparound" as defined in OAR 309-019-0105, "Behavior Supports, Crisis Care" as defined in OAR 309-019-0105, "Respite Care" as defined in OAR 309-019-0105, and "Intensive Outpatient Services and Supports" as defined in OAR 309-019-0165;¶
(b) Behavioral Health Peer Delivered Services as defined in OAR 309-019-0125 from within the MCE's Provider Network;¶
(c) Medication-Assisted Treatment for Substance Use Disorders as defined in OAR 309-019-0105, including opioid and opiate use disorders. Prior authorization may only be required:¶
(A) For a medication approved by the United States Food and Drug Administration after January 1, 2024; or¶
(B) For a brand name drug for medication-assisted treatment if a generic equivalent is available to substitute for the prescribed brand name drug. For the purposes of this rule, a different formulation of the medication is not a generic equivalent.¶
(5) Contractors must permit out-of-network IHCPs to refer an MCE-enrolled American Indian/Alaska Native to a network provider for covered services as required by 42 CFR 438.14(b)(6).¶
(6) The MCE shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-3830.¶
(7) MCEs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.¶
(8) MCEs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. MCEs shall observe required timely access to service timelines as indicated in OAR 410-141-3515.¶
(9) MCEs may place appropriate limits on a service authorization for Covered Services based on Medical Necessity and Medical Appropriateness as defined in OAR 410-120-0000, or for utilization control provided that the MCE:¶
(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;¶
(b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;¶
(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20 and the member's free choice of provider consistent with 42 USC § 1396a(a)(23)(B) and 42 CFR § 431.51; and¶
(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.¶
(10) MCEs may not use quality of life in general measures in establishing utilization controls (e.g.,-prior authorization) or otherwise making benefit determinations per OAR 410-120-1320.¶

(11) Once a member is determined to be eligible for HRSN Services as outlined in OAR 410-120-2000, OAR 410-120-2005, and OAR 410-120-2015, MCEs may place appropriate limits on a service authorization for HRSN Services or for utilization control provided the MCE:¶
(a) Ensures the HRSN Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and¶
(b) Authorizes the HRSN Services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;¶
(c) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue the delivery of HRSN Services to any member who is eligible for those services under OAR 410-120-2000, OAR 410-120-2005, and OAR 410-120-2015.¶
(12) For authorization of services:¶
(a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:¶
(A) For standard authorization requests for services not previously authorized and not for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice as expeditiously as the member's condition requires and no later than ~~fourteen (14~~ seven calendar (7) days following receipt of the request for service ~~with a possible~~. An extension of up to ~~F~~fourteen (14) additional days is possible if the following applies:¶
(i) The member, the member's representative, or provider requests an extension; or¶
(ii) The MCE ~~justifies to~~needs additional information to process the request, and the extension is in the member's interest. If the Authority ~~upon~~ requests, the MCE will justify a need for the additional information and how the extension is in the member's interest.¶
(B) For expedited authorization decisions:¶
(i) The MCE shall provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;¶
(ii) The MCE may extend the 72 hour period up to fourteen (14) days if the member requests an extension or if the MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.¶
(C) For all prior authorization requests for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice as expeditiously as the member's condition requires and no later than 72 hours following receipt of the request for service.¶
(b) Prior authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the MCEs as follows:¶
(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5) of the Social Security Act. An initial response shall include:¶
(i) A written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing practitioner, and when known to the MCE, the pharmacy; or¶
(ii) A written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved; or¶
(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the MCE's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or¶
(iv) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay a decision to approve or deny the drug within 72 hours.¶
(B) The 72 hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug;¶
(C) If the response is a request for additional documentation, the MCE shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:¶
(i) Upon receiving the MCE's completed prior authorization forms and required documentation, the MCE shall issue a decision as expeditiously as the member's health requires, but no later than 72 hours from the date and time stamp of the initial request for prior authorization as follows:¶
(I) If the drug is approved as requested, the MCE shall notify the member in writing and prescribing practitioner, and when known to the MCE, the pharmacy, telephonically, or electronically; or¶
(II) If the drug is denied or partially approved, the MCE shall issue a written notice of adverse benefit

determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.¶
(ii) If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.¶
(D) The MCE shall provide approved services as expeditiously as the member's health condition requires;¶
(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the MCE makes a coverage decision.¶
(c) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;¶
(d) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;¶
(e) MCEs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR § 438.404 and OAR 410-141-3885;¶
(f) The MCE and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:¶
(A) For medical, behavioral, or oral health Covered Services:¶
(i) The MCE shall consult with the requesting provider for medical, behavioral, or oral health services when necessary:¶
(I) Requesting all the appropriate information to support decision making as early in the review process as possible; and¶
(II) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.¶
(ii) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:¶
(I) Deny a service authorization request;¶
(II) Reduce a previously authorized service request; or¶
(III) Authorize a service in an amount, duration, or scope that is less than requested.¶
(B) For HRSN Services, the MCE shall comply with OAR 410-120-2020.¶
(C) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify timeframes for the following:¶
(i) Date and time stamping prior authorization requests when received;¶
(ii) Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid;¶
(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;¶
(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;¶
(v) Providing services after office hours and on weekends that require prior authorization.¶
(D) An MCE shall make a determination on at least 95 percent of valid prior authorization requests within two (2) ~~working~~business days of receipt of a prior authorization or reauthorization request related to:¶
(i) Drugs;¶
(ii) Alcohol;¶
(iii) Drug services; or¶
(iv) Care required while in a skilled nursing facility.¶
(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within ~~fourteen (14~~seven calendar (7) days of receipt of the request as set forth in OAR 410-141-3885 unless otherwise specified in OHP program rules:¶
(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the ~~fourteen (14~~seven calendar (7) day period;¶
(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;¶

(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.¶
(13) Report to the Authority annually requests for prior authorization. The report shall include:¶
(a) The number of requests received;¶
(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;¶
(c) The number of requests that were initially approved; and¶
(d) The number of denials that were reversed by internal appeals or external reviews.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.651, 414.615, 414.625, 414.635
Statutes/Other Implemented: ORS 414.065, 414.610-414.685

AMEND: 410-141-3845

RULE SUMMARY: Rename “Health-Related Services” to “Flexible Services” and clarify language regarding member-level and community-level services.

CHANGES TO RULE:

410-141-3845
Health-Related Services
(1) The goals of ~~Health-Related~~Flexible Services ~~(HRS)~~ are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. ~~Health-related s~~Flexible Services are provided as a ~~sup~~complement to covered health care services:¶
(a) ~~HRS~~Flexible Services may be provided a~~s flexible services or as community benefit initiati~~t the member- or community-le~~ves~~l~~, as ~~those terms are~~ defined below;¶
(b) CCOs have the flexibility to identify and provide ~~health-related s~~Flexible Services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the ~~HRSy~~ satisfy the requirements of this rule;¶
(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from ~~HRS~~Flexible Services and delivered at the complete discretion of the CCO;¶
(d) ~~HRS~~Flexible Services may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.¶
(2) To qualify as ~~an HRS~~Flexible Services within the meaning of this rule, a service must meet the following requirements, consistent with 45 CFR § 158.150:¶
(a) The service must be designed to:¶
(A) Improve health quality;¶
(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;¶
(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and¶
(D) Be based on any of the following:¶
(i) Evidence-based medicine; or¶
(ii) Widely accepted best clinical practice; or¶
(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.¶
(b) The service must be primarily designed to achieve at least one of the following goals:¶
(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;¶
(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;¶
(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;¶
(D) Implement, promote, and increase wellness and health activities;¶
(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.¶
(c) The following types of expenditures and activities are not considered ~~HRS~~Flexible Services:¶
(A) Those that are designed primarily to control or contain costs;¶
(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;¶
(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;¶
(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;¶
(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;¶
(F) All retrospective and concurrent utilization review;¶
(G) Fraud prevention activities;¶
(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;¶
(I) Provider credentialing;¶
(J) Costs associated with calculating and administering individual member incentives; and¶

(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.¶
(3) CCOs shall implement Policies and Procedures (P&Ps) for ~~HRS~~Flexible Services. These P&Ps shall be submitted to the Authority for approval:¶
(a) ~~HRS~~Flexible Services P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability;¶
(b) A CCO's ~~HRS~~Flexible Services spending ~~on~~at the community ~~benefit initiati~~-leve~~s~~l shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any ~~HRS~~ community ~~benefit initiative~~-level Flexible Services spending priorities identified by the Authority;¶
(c) The P&Ps shall describe how ~~HRS~~Flexible Services spending decisions are made, including the role of the CAC and tribes in community ~~benefit initiativ~~-level Flexible Services spending decisions;¶
(d) CCOs shall not limit the range of permissible ~~health-related s~~Flexible Services by any means other than by enforcing the limits defined in this rule.¶
(4) Member-level Flexible ~~s~~Services are cost-effective services offered to an individual member as an adjunct to covered benefits. Member-level Flexible ~~s~~Services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the ~~HRS~~Flexible Services needed to supplement the member's care:¶
(a) CCOs shall provide members with a written notification of a refusal of ~~individua~~a member-level ~~f~~Flexible ~~s~~Services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;¶
(b) A CCO's refusal to permit ~~an individua~~ member-level ~~f~~Flexible ~~s~~Services request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915.¶
(5) Community ~~benefit~~-level Flexible Services initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality. CCOs shall designate a role for the community advisory council in ~~health-related services community benefit initiative~~community-level Flexible Services spending decisions.¶
(6) CCOs shall submit their financial reporting for ~~health-related s~~Flexible Services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).¶
(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for ~~HRS~~Flexible Services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-3855

RULE SUMMARY: Carve out drugs appearing on a new High Cost, Rarely Used Drug Carve-out (HCRU) List from CCO capitation. Define process for adding drugs to or removing drugs from the HCRU List.

CHANGES TO RULE:

410-141-3855
Pharmaceutical Services
(1) Prescription drugs are a covered service for conditions that are described in the funded region of the Prioritized List of Health Services, as described in OAR 410-141-3820. MCEs shall pay for covered prescription drugs except:¶
(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants) (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);¶
(b) FDA-approved formulations of valproic acid and its derivatives, lamotrigine, and xanomeline/trospium and those drugs used to treat severe mental health conditions that the Authority specifically carved out from capitation according to section (1~~0~~1) of this rule;¶
(c) Drugs covered under Medicare Part D when the member is fully dual eligible; and¶
(d) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act, for which payment is governed by OAR 410-121-0150.¶
(e) Drugs appearing on the High Cost, Rarely Used Carve-Out Drug List (HCRU List) dated 1/1/2026, appearing at www.orpdl.org, and included here by reference. MCEs will be responsible for all other associated costs, including non-emergency medical transportation, care coordination, inpatient hospital services and other medically necessary expenses.¶
(A) Drugs meeting the following general criteria will be considered by the Authority for inclusion on the HCRU List:¶
(i) Have an estimated acquisition cost of more than $500,000 per member over a 12-month period;¶
(ii) Are indicated for rare conditions; and¶
(iii) Have few alternatives, as determined by the Authority.¶
(B) To add a drug to or remove a drug from the HCRU List:¶
(i) The MCE shall submit a request to the Authority containing all the following information:¶
(I) The drug name;¶
(II) Whether the drug is recommended to be added to or removed from the HCRU List;¶
(III) The estimated per member acquisition cost of the drug for a 12-month period;¶
(IV) The FDA-approved indications for the drug;¶
(V) Any alternative treatments to the drug for these indications; and¶
(VI) Any additions considerations the Authority should give to adding or removing the drug.¶
(ii) If the Authority approves an MCE request for a drug to be added to or removed from the HCRU List, the Authority shall revise the HCRU List and amend subsection (e) of this section (1) according to the rulemaking process described in ORS 183.333-183.335 effective no later than:¶
(I) The following January 1st, for requests submitted between January 15th - July 14th;¶
(II) The following July 1st, for request submitted between July 15th - January 14th.¶
(iii) The Authority may add a drug to or remove a drug from the HCRU List at any time using the rulemaking process described in ORS 183.333-183.335.¶
(2) MCEs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.¶
(3) MCEs may use a preferred drug list if it allows access to other drug products not on the drug list through prior authorization.¶
(4) As specified in 45 CFR 156.122 and 42 CFR 438.10, MCEs shall publish up-to-date, accurate, and complete preferred drug lists, including any tiering structures, that have been adopted and any coverage criteria or other restrictions on the way certain drugs may be obtained. MCEs shall ensure that:¶
(a) The preferred drug list is easily accessible to members and potential members, state and federal government, and the public;¶
(b) The preferred drug list is accessible on the MCE's public website in a machine-readable format through a clearly identifiable web link or tab without requiring a member to access account or policy number;¶
(c) Be made available in paper form if requested by a member; and¶
(d) If an MCE has more than one plan, members may be easily able to discern which preferred drug list applies to which plan.¶
(5) The preferred drug list shall:¶
(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to

ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;¶
(b) Include at least one item in each therapeutic class of over-the-counter medications; and¶
(c) Be revised periodically to assure compliance with this requirement.¶
(6) MCEs shall cover at least one form of contraception within each of the 18 methods identified by the FDA. As set forth in OAR 410-141-3515, the member may refer themselves directly to family planning services without getting a referral from a PCP or other participating providers.¶
(7) Prior Authorization for prescription drug requests shall be addressed by the MCEs as described in OAR 410-141-3835.¶
(8) MCEs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the prescriber certifies medical necessity for the drug such as:¶
(a) The equivalent of the drug listed has been ineffective in treatment; or¶
(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.¶
(9) MCEs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the federal "Drug Products in the Medicaid Drug Rebate Program" list available at: https://data.medicaid.gov/¶
(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121), unless otherwise provided in this rule. An MCE may not reimburse providers for drugs carved-out ~~drugs.¶~~
~~(a) Adding drugs to the carve-out list.¶~~
~~(A) An MCE may seek to add~~in section (1) of this rule.¶
(11)(a) Adding mental health drugs to the carve-out list ~~contained~~ in subsection (1)(b) of this rule:¶
(A) An MCE may seek to add drugs by submitting a request to the Authority. The request must contain all the following information:¶
(i) The drug name;¶
(ii) The FDA-approved indications that identify the drug may be used to treat a severe mental health condition, along with any other FDA-approved indications; and¶
(iii) The reason the Authority should consider this drug for carve out.¶
(B) If the Authority approves an MCE request for a drug not to be paid within the global budget, the Authority shall:¶
(i) Amend subsection (1)(b) of this rule according to the process described in ORS 183.335(5) within sixty (60) days of the request to exclude the drug from the global budget if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders;¶
(ii) Within 180 days of amending subsection (1)(b) of this rule as described in subsection (i), adopt this same amendment to subsection (1)(b) using the permanent rulemaking process described in ORS 183.335(1)-(4).~~¶~~
(C) The Authority may add drugs ~~to the carve-out list~~ at any time using the rulemaking process described in ORS 183.333-183.335.¶
(b) Removing mental health drugs from the carve-out list~~.~~ in subsection (1)(b) of this rule:¶
(A) An MCE may seek to remove drugs ~~from the carve-out list contained in section (1) of this rule~~ by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all the following information:¶
(i) The drug name;¶
(ii) The FDA approved indications for the drug; and¶
(iii) The reason the Authority should consider removing this drug from the list of carved out drugs.¶
(B) If the Authority approves an MCE request for a carved-out drug to be paid within the global budget, the Authority shall include the drug in the global budget for the following January contract cycle.¶
(C) The Authority may remove drugs ~~from the carve-out list~~ in conjunction with a January contract cycle using the rulemaking process described in ORS 183.333-183.335.¶
(1~~1~~2) MCEs shall submit quarterly encounter data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.¶
(1~~2~~3) MCEs are encouraged to provide payment only for outpatient and physician-administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. MCEs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.¶
(1~~3~~4) MCEs shall utilize a Pharmacy and Therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, if all committee requirements for both

committee types are met:¶
(a) A P&T committee must maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR § 156.122(3)(i) and (ii). Meetings shall be held at least quarterly;¶
(b) MCEs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations;¶
(c) The committee in its DUR capacity shall assure prescriptions are appropriate, medically appropriate, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined and described by 42 CFR 456, subpart K and Section 1902(oo) of the Social Security Act [42 U.S.C. 1396a(oo)].¶
(145) As required by ORS 414.328, CCOs shall implement a synchronization policy for the dispensing of prescription drugs to members of the CCO. A "synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.¶
(156) Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A.655 before prescribing a schedule II controlled substance pursuant to 42 U.S.C 1396w-3a:¶
(a) Providers shall maintain documentation of the prescription drug history of the individual being treated; and¶
(b) In the case that an enrolled provider is not able to conduct the PDMP check, the providers shall maintain documentation of efforts, including reasons why the provider was unable to conduct the check;¶
(c) The PDMP check does not apply to clients in exempt populations:¶
(A) Individuals receiving hospice care;¶
(B) Individuals receiving palliative care;¶
(C) Individuals receiving cancer treatment;¶
(D) Individuals with sickle cell disease;¶
(E) Residents of long-term care facilities described in) 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w-3a(h)(2)(B); and¶
(F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.¶
(d) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610-414.685

AMEND: 410-141-3870

RULE SUMMARY: Include care coordination requirements for members transitioning from FFS to a CCO. Increase the maximum Post Hospitalization Extended Care (PHEC) benefit from 20 days to 100 days per SB 296.

CHANGES TO RULE:

410-141-3870
Care Coordination: Service Coordination
(1) Coordinated Care Organizations (CCOs) must ensure all services accessed by members are coordinated according to the needs of members, following the requirements in OAR 410-141-3860, OAR 410-141-3865 and in this rule.¶
(2) Upon enrollment, CCOs must act promptly to ensure services are coordinated for members needing Urgent Care Services or Emergency Services as defined in OAR 410-120-0000, even if the Member has not yet selected a Primary Care Provider (PCP) or completed a Health Risk Assessment (HRA).¶
(3) CCOs must formally designate a position or team as primarily responsible to coordinate individual services accessed by the Member and must provide information to the Member on how to contact their designated person or team initially and when the designated position or team changes.¶
(4) CCOs shall utilize a Care Profile for all members as defined in OAR 410-141-3500. The Member Care Profile must identify:¶
(a) The Member's identifying demographic information;¶
(b) The Member's communication preferences and needs (e.g. preferred language, method of communication, Alternate Formats, Auxiliary Aids and Services);¶
(c) The Member's care team, along with their contact information, role, and any assigned Care Coordination responsibilities. This must include, but is not limited to;¶
(A) The persons or teams formally designated by the CCO as primarily responsible for coordinating the services accessed by the Member;¶
(B) All providers serving the Member, including, at minimum, their Primary Care Provider; and¶
(C) The identified individuals from all entities serving the member, such as those listed in 410-141-3860(2).-¶
(d) A summary of the Member's needs; and¶
(e) The Member's preferences, when available, to the extent the Member desires to participate; and-¶
(f) The Member's health risk score and risk level, as described in OAR 410-141-3860;¶
(g) Any open or closed Care Plans; and¶
(h) An overview of the supports, services, activities, and resources that have been or shall be deployed to meet the Member's identified needs.¶
(5) CCOs must ensure services are actively coordinated for members when requested by the Member, their representative or guardian, an involved provider or entity, or when required by the Member's needs and risk level as identified in the Member's Care Profile. This coordination is accomplished through the development and implementation of a Care Plan that scales in complexity relative to the needs, goals, preferences, and circumstances of the Member.¶
(a) CCOs shall consider the Member's identified risk level to determine if a Care Plan is required.¶
(A) Members in the no- or low-risk levels do not require a Care Plan unless the Member's needs change resulting in a higher risk level or when the Member requests it;¶
(B) Members within the moderate-risk and high-risk levels, or who require Long Term Service and Supports (LTSS) must have a Care Plan developed.-¶
(C) For Members identified as moderate or high risk who decline participation in Care Plan development, CCOs shall ensure Care Plans at minimum document:¶
(i) The Member's physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity), when available; and¶
(ii) The services and activities the CCO have or will deploy to focus on mitigation of the Member's identified risks and level; and¶
(iii) The outreach attempts and opportunities for engagement the CCO continues to provide to the Member; and-¶
(iv) The reason the Member has declined or is otherwise unable to participate in the development of their Care Plan.-¶
(D) For Members receiving Long Term Services and Supports (LTSS), the CCO shall have access to or integrate any service or Care Plans developed by entities listed in OAR 410-141-3865(6) into the Member's Care Profile or Care Plan.-¶
(b) The Care Plan is developed or revised as required in (5)(d) of this rule and in alignment with:¶
(A) The Member's identified needs and risk level; and-¶
(B) With identification of the Member's goals and preferences, when available, to the extent the Member desires

or is able to participate; and-¶
(C) By incorporating information from any relevant assessments, treatment and service plans from providers or community partners involved in the Member's care, to the maximum extent feasible;¶
(D) In consultation with any other provider, case manager, or entity providing services to, or coordinating care for, the Member;¶
(E) In consultation with a clinician that has the appropriate clinical qualifications and expertise to review and revise the Care Plan considering the Member's complex physical, developmental, behavioral or oral health care needs including clinical subjectivity;¶
(F) In accordance with a Member's updated risk level as described in (4)(f) of this rule;¶
(G) With the Member, their representative or guardian's participation to the extent they desire or are able to participate. The Member, their representative or guardian shall be satisfied with and understand the Care Plan, including any of their own roles and responsibilities.¶
(i) If participation in creating a Member's Care Plan may be significantly detrimental to the Member's care or health, the Member, the Member's caregiver, or the Member's family may be excluded from the development of a Care Plan;-¶
(ii) The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the Member, and describe what attempts were made to address the concern(s); and¶
(iii) This decision must be reviewed prior to each significant Care Plan update resulting from a health-related circumstance change as set forth in OAR 410-141-3865(3)(g). The decision to continue the exclusion shall be documented.¶
(H) In accordance with state quality assurance and utilization review standards, as applicable.¶
(c) After development of the Care Plan, CCOs must make it promptly available to the Member, the Member's representative or guardian and to all relevant providers rendering services to the Member who shall coordinate and provide services according to it:¶
(A) The Member, the Member's representative or guardian must be provided immediate electronic access, or a copy in the Member's preferred method of communication and in the Member's preferred language. Auxiliary Aids and Services and Alternate Formats must be made available upon request of the member at no cost within five (5) business days of the request.¶
(B) If the CCO requires Care Plans to be approved, approval must be timely, according to a Member's needs; and¶
(C) If providing the Member with a copy of or access to their full Care Plan may be significantly detrimental to their care or health, as determined by the Member's care team, CCOs may withhold from the Member, only those parts of the plan that are determined to be detrimental. The CCO must:¶
(i) document the reasons for withholding the full or partial Care Plan, including a specific description of the risk or potential harm to the Member, and describe what attempts were made to address the concern(s); and¶
(ii) This decision to withhold the Care Plan in full or in part must be reviewed prior to each Care Plan update, and the decision to continue withholding the Care Plan in full or in part shall be documented.¶
(d) Open Care Plans must be reviewed and revised at least annually, or¶
(A) When a Member, Member representative or guardian, or any provider serving the Member requests a review or revision; or¶
(B) Upon a change in health-related circumstances as described in OAR 410-141-3865(3)(g).¶
(e) The Care Plan may be closed and the Member shall continue with Care Profile tracking when;¶
(A) No longer warranted by the Member's risk level or circumstances; or-¶
(B) Requested by the Member, their representative or guardian when the member no longer desires to participate; or¶
(C) There is no contact with the Member, their representative or guardian after a minimum of three (3) attempts of outreach, utilizing at least two (2) mixed modalities (e.g., paper, digital or verbal) including the Member's preferred method of communication and language, over a sixty (60) day period and with consultation and agreement of all available care team Members.-¶
(D) If the associated risk level of a Member remains a moderate, high or LTSS and the Member no longer wishes to participate the CCO must close the Care Plan and transition to a CCO directed Care Plan as outlined in (5)(a)(B) and (5)(a)(C) of this rule.-¶
(6) CCOs shall ensure Care Coordination for all members, regardless of where the Member is receiving services.¶
(a) If members experience a Care Setting Transition CCOs must ensure:¶
(A) Members are transitioned into the most appropriate independent and integrated community settings and provided follow-up services as medically necessary and appropriate prior to discharge to facilitate successful handoff to community providers;¶
(B) Appropriate discharge planning and Care Coordination for adults who were Members upon entering the Oregon State Hospital (OSH) and who shall return to their home CCO upon discharge from the Oregon State Hospital;¶

(C) Care Coordination and discharge planning for out of service area placements, for which an exception shall be made to allow 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.¶
(b) Coordinate and authorize care when it has been deemed medically appropriate and medically necessary to receive services outside of the service area because a provider specialty is not otherwise contracted with the CCO;¶
(c) Coordinate the Member's care when they are temporarily outside their enrolled service area;¶
(d) If members are transitioning between CCOs or ~~CCO to~~to or from fee-for-service (FFS) as set forth in OAR 410-141-3850;¶
(e) Post Hospital Extended Care must be provided in accordance with OAR 411-070-0033:¶
(A) Post Hospital Extended Care ~~Coordination (PHEC) is a twenty (20) day benefit~~(PHEC) is a benefit of up to one hundred (100) days included within the Global Budget and the CCO shall pay for the full ~~twenty (2~~one hundred (100) day PHEC benefit when the full ~~twenty (2~~one hundred (100) days is required by the discharging provider. CCOs shall make the benefit available to non-Medicare Members who meet Medicare criteria for a post-Hospital Skilled Nursing Facility placement.¶
(B) CCOs shall notify the Member's local ODHS APD office prior to the Member being admitted to PHEC. Upon receipt of such notice, CCO and the Member's APD office must promptly begin appropriate discharge planning.¶
(C) CCOs shall notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no less than two (2) full days prior to discharge.¶
(D) CCOs shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to Durable Medical Equipment (DME), medications, home and Community based services, discharge education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to:¶
(i) attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; or¶
(ii) schedule follow-up care appointments with Providers that the Member may need to see;¶
(iii) or both (i) and (ii).¶
(E) CCOs shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at www.medicare.gov/publications¶
(F) CCOs are not responsible for the PHEC benefit unless the Member was enrolled with the CCO at the time of the hospitalization preceding the PHEC facility placement.¶
(7) In addition to the care planning requirements above, for LTSS or Special Health Care Needs Members as defined in OAR 410-120-0000 that are assessed according to OAR 410-141-3865(5) to have an ongoing special condition that requires a course of treatment or regular care monitoring or identified as high risk:¶
(a) CCOs must consider the above members, according to their needs, during Interdisciplinary Team Meetings which are convened and facilitated as needed according to the Member's Care Plan, including a post-transition meeting of the interdisciplinary team within fourteen (14) days of a transition between levels, settings or episodes of care. These meetings must:¶
(A) Include the Member, their representative or guardian, unless the Member declines or the Member's participation is determined to be significantly detrimental to the Member's health, in accordance with (5)(b)(G) of this rule;¶
(B) Invite and consider relevant information from all providers and other entities serving the Member including but not limited to those listed in OAR 410-141-3860(2); and¶
(C) Provide a forum to:¶
(i) Describe the clinical interventions recommended to the treatment team and identify the frequency of necessary Interdisciplinary Team Meetings appropriate to meet the Care Plan needs;¶
(ii) Create a space for the Member to provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meeting;¶
(iii) Identify coordination gaps and strategies to improve Care Coordination with the Member's service providers;¶
(iv) Develop strategies to identify, address, monitor and follow up on needed referrals for specialty care, routine health care services (including medication monitoring), other community programs or social need services; and¶
(v) Align and update the Member's individual Care Plan and share the plan in accordance with (5)(c) of this rule.¶
(b) CCOs must implement a mechanism to provide direct access to specialists, e.g., a standing referral or an approved number of visits, as appropriate for the Member's condition and identified needs.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3885

RULE SUMMARY: Indicate practitioner name is not required on notices of adverse benefit decisions (NOABDs) for non-emergent medical transportation (NEMT) services. Clarify language regarding documentation needed when a member withdraws a request for services, which impacts when a CCO needs to give advance notice of a previously authorized service being reduced, terminated or suspended. Correct a reference to a federal regulation.

CHANGES TO RULE:

410-141-3885
Grievances & Appeals: Notice of Action/Adverse Benefit Determination
(1) When a Managed Care Entity (MCE) has made an adverse benefit determination, the MCE shall give the requesting provider, the Member and the member's representative a written Notice of Adverse Benefit Determination (NOABD). 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.¶
(2) The following are notice requirements for preservice 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 including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages;¶
(B) Date of the notice;¶
(C) ~~N~~For notices not pertaining to non-emergency medical transportation (NEMT) services, the name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) 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 ninety (90) days, the NOABD shall 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 and the adverse benefit determination the MCE intends to make, including whether the MCE is denying, (in whole or part) terminating, suspending, or reducing a service;¶
(F) Date service was requested by the provider or member;¶
(G) Name of the provider who 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 of all codes in plain language. For services that do not include a procedure code a description of the requested service;¶
(J) Whether the MCE considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services pursuant to OAR 410-141-3820 and 410-141-3830;¶
(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;¶
(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 NOABD;¶
(M) The Member, member representative or, the provider with the member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within sixty (60) days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(N) The Member, member representative or the provider with the member's written consent has the right to request a contested case hearing either orally or in writing with the Authority 120 days from the date of the MCE's Notice of Appeal Resolution or where the MCE failed to meet appeal timelines (standard appeal sixteen (16) days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3890, expedited appeal 72 hours to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3895), and the procedures to exercise that right;¶
(O) The circumstances under which an appeal process or contested case hearing can be expedited and how the

Member, member representative or the member's provider may request it. If the MCE denies a request for an expedited appeal, it shall be transferred to the standard appeal resolution timeframes;¶
(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing and that continued benefits can be requested by the Member or member's representative. The timeframes to request that benefits be continued and the circumstances under which the member may be required to pay the cost of these services as described in OAR 410-141-3910 ;¶
(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;¶
(R) Information on requesting help and who to contact;¶
(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines; and¶
(T) Inclusion of the names of providers, clinics or member's representative copied on the notice;¶
(b) Use an Authority approved NOABD 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 NOABD.¶
(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 including name, address, and telephone number and subcontractor contact information, if applicable, included in the NOABD excluding any cover pages;¶
(B) Date of the notice;¶
(C) ~~N~~For notices not pertaining to non-emergency medical transportation (NEM) services, the name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) 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 ninety (90) days, the NOABD shall state PCP, PCD, BH provider assignment has not occurred;¶
(D) Member's name, D.O.B, address, and OHP member ID number;¶
(E) Service previously provided in plain language and the adverse benefit determination the MCE made;¶
(F) Date the service was provided;¶
(G) Name of the provider who provided the service;¶
(H) Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;¶
(I) Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language. For services that do not include a procedure code a description of the service provided in plain language;¶
(J) Whether the MCE considered other conditions such as co-morbidity factors if the condition 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. NOABD shall clearly indicate whether a medical review was performed and if not that the provider can resubmit claim with chart notes for review of comorbidity;¶
(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;¶
(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;¶
(M) The Member, member representative or, the provider with the member's written consent as required under OAR 410-141-3890(1), may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within 60 days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶
(N) The Member, member representative or the provider with the member's written consent has the right to request a contested case hearing either orally or in writing with the Authority 120 days from the date of the MCE's Notice of Appeal Resolution or where the MCE failed to meet appeal timelines (standard appeal 16 days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension 410-141-3890, expedited appeal seventy two (72) hours to review and resolve appeal from date of receipt with a possible 14 day extension 410-141-3895) and the procedures to exercise that right;¶
(O) 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, member representative or the member's provider may request it,

but that an expedited appeal and hearing shall not be granted for post-service denials as the service has already been provided;¶
(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing and that continued benefits can be requested by the Member or member's representative. The timeframes to request that benefits be continued and the circumstances under which the member may be required to pay the cost of these services as described in OAR 410-141-3910 ;¶
(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; and¶
(R) 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);¶
(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines;¶
(T) Information on requesting help and who to contact; and¶
(U) Inclusion of the names of providers, clinics or member's representative copied on the notice.¶
(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 NOABD.¶
(4) The MCE shall provide a copy of the ~~following when an NOABD is issued:¶~~
~~(a)~~ Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile~~;~~ when an NOABD is issued.¶
(~~b~~5) The MCE may provide a copy of the Non-Discrimination Policy when an NOABD is issued.¶
(~~5~~6) For requirements of NOABD that affect services previously authorized, the MCE shall mail the notice at least ten (10) days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.¶
(~~6~~7) 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~~a signed, written notice from the member that the services previously requ~~ir~~es ~~t~~ermination or reduction in services:¶
~~(i) All notices sent to a member under this section shall be in writing,~~d are no longer desired and clearly indicates the member understands that the services previously requested shall 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 may 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 location 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 has:¶
(A) Facts indicating that an adverse benefit determination may be taken because of probable fraud on part of the member; and¶
(B) 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.¶
(~~7~~8) Within sixty (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 4~~83~~8.408, the Authority may consider the MCE appeals process exhausted.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3890

RULE SUMMARY: Remove duplicative language.

CHANGES TO RULE:

410-141-3890
Grievances & Appeals: Appeal Process
(1) A member, member representative, or provider with the member's written consent, may file an oral or written appeal with the Managed Care Entity (MCE) to:¶
(a) Express disagreement with an adverse benefit determination; or¶
(b) Oral appeals 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 to reach the member (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.¶
(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.¶
(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 (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;¶
(B) Within two (2) 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;¶
(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.¶
(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) shall not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above section (3) of this rule.¶
(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 (a) 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;¶
(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 member and their representative; or¶
(b) The legal representative of a deceased Member's estate.¶
(8) The MCE shall resolve each standard appeal in time period defined above in section (4) of this rule. 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. The MCE must take the following steps:¶
(a) notify the Member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;¶
(b) Enter the prior authorization into the system or adjust the encounter data claim representing the service.¶
(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those

services in accordance with the Authority policy and regulations.¶
(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of adverse benefit determination, as specified in OAR 410-141-3885, in addition to:¶
(a) The date the member filed the appeal with the MCE;¶
(b) The results of the resolution process and the date the MCE completed the resolution;¶
(c) Effective date of the appeal decision;¶
(d) For appeals resolved partially or wholly in favor of the member, an explanation that the member may now access those benefits that were denied and how to do so; and¶
(e) 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: Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.¶
~~(f) For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.~~
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3900

RULE SUMMARY: Clarify language on the appeals/contested case hearing timeframes. Remove potentially confusing use of the word “appeals” in the context of contested case hearings.

CHANGES TO RULE:

410-141-3900
Grievances & Appeals: Contested Case Hearings
(1) A Managed Care Entity (MCE) shall have a system in place to ensure its members and providers ~~have access to appeal for MCE's action by request~~acting on behalf of a member can request that the Authority review a final adverse determination by the MCE ing a contested case hearing:¶
(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures;¶
(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;¶
(c) Appeals brought on the provider's own behalf are not subject to this rule, ~~which governs appeals brought by member or by a provider on the member's behalf~~ but are governed by OAR 410-120-1560.¶
(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3) of this rule, below:¶
(a) The member shall file a hearing request with the Authority using form OHP 3302 or any other Oregon Health Authority (Authority)-approved ~~appeal or~~ hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;¶
(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two (2) business days of the Authority's request;¶
(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:¶
(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;¶
(B) Respond to the request for the appeal ~~within 16 days and provide the member with a notice of appeal resolution~~in accordance with 410-141-3890.¶
(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:¶
(A) Date-stamp the hearing request with the date of receipt; and¶
(B) Submit the following required documentation to the Authority within two business days:¶
(i) A copy of the hearing request notice of adverse benefit determination, and notice of appeal resolution;¶
(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.¶
(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.¶
(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.¶
(5) The parties to a contested case hearing include, as applicable:¶
(a) The member and their representative; or¶
(b) The legal representative of a deceased Member's estate; and¶
(c) The MCE.¶
(6) The Authority shall refer the hearing request along with the notice of adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are

requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.¶
(7) The Authority shall issue a final order~~,~~ or other ~~Authority shall~~rwise resolve the case ordinarily within ninety (90) days from the date the MCE receives the member's request for appeal. The ninety (90) day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request. The Authority must issue the final order within this time frame except in unusual circumstances, documented in the member's record, when:¶
(a) The agency cannot reach a decision because the member requests a delay or fails to take a required action; or¶
(b) There is an administrative or other emergency beyond the Authority's control.¶
(8) For reversed hearing resolution services:¶
(a) For services not furnished while the appeal or hearing is pending. If 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. The MCE must take the following steps:¶
(A) notify the Member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;¶
(B) Enter the prior authorization into the system or adjust the encounter data claim representing the service.¶
(b) For services furnished while the appeal or hearing is pending. If the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.¶
(c) Any party to the hearing can file written exceptions or present argument to the Proposed and Final Order within ten working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of the MCE receiving the Final Order.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3955

RULE SUMMARY: Define “chronic lateness” and specify that it can lead to a CCO modifying NEMT services for a member.

CHANGES TO RULE:

410-141-3955
Transportation: Member Service Modifications and Rights
(1) For the purposes of this rule, "direct threat" means a significant risk to the health or safety of others and which:¶
(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes; and¶
(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence which shows:¶
(A) The nature, duration, and severity of the risk;¶
(B) The probability that a potential injury will actually occur; and¶
(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.¶
(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles which shall include, without limitation, policies and procedures that comply with this rule. CCOs shall provide its passenger safety policy and procedures to its NEMT subcontractors and require the NEMT subcontractors to implement and follow such policies and procedures. The CCOs' passenger safety policy and procedures shall be included in their member handbooks and posted on their websites.¶
(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.¶
(4) CCOs may not apply criteria, standards, or practices that screen out, or tend to screen out, individuals in a protected class, as defined under state anti-discrimination laws, from fully and equally enjoying any goods, services, programs, or activities unless:¶
(a) The criteria can be shown to be necessary for providing those goods and services; or¶
(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.¶
(5) A CCO may modify NEMT services when the member:¶
(a) Threatens harm to the driver or others in the vehicle;¶
(b) Presents a direct threat to the driver or others in the vehicle;¶
(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm;¶
(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services;¶
(e) Frequently does not show up for scheduled rides;¶
(f) Exhibits chronic lateness, defined as being more than 15 minutes late after the driver arrives (within the pickup window) for 25% or more of those trips occurring within the previous three-months; or¶
(~~f~~g) Frequently cancels the ride on the day of the scheduled ride time.¶
(6) A member may request modification of NEMT services when the NEMT driver:¶
(a) Threatens to harm the member or others in the vehicle;¶
(b) Drives or engages in other behavior that places the member or others in the vehicle at risk of harm; or¶
(c) Presents a direct threat to the member or others in the vehicle.¶
(7) Reasonable modifications include, but are not limited to, requiring members to:¶
(a) Use a specific transportation provider;¶
(b) Travel with an attendant;¶
(c) Use public transportation where available;¶
(d) Drive or locate someone to drive the member and receive mileage reimbursement; and¶
(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.¶
(8) Members shall be advised at the time of request for NEMT services of the need for accommodation which shall be followed by written confirmation to the member, the member's care coordinator, and any requesting provider. Before modifying services, the NEMT provider, a CCO representative, and the member shall:¶
(a) Communicate about the reason for imposing a modification;¶
(b) Explore options that are appropriate to the member's needs; and¶
(c) Address health and safety concerns.¶
(9) The communications discussed in section (8) of this rule may include:¶
(a) The member's care team, including any care coordinator, at the request or upon approval of the member or the CCO;-¶
(b) Any other individual of the member's choosing.¶

(10) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.¶
(11) A CCO may not modify NEMT services under this rule unless the modification is permitted under this rule or required in order to accommodate a disability requiring modification or auxiliary aid.¶
(12) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.¶
(13) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.
Statutory/Other Authority: ORS 413.042, ORS 414.625
Statutes/Other Implemented: ORS 414.625

AMEND: 410-141-3960

RULE SUMMARY: Align CCO NEMT meal reimbursement criteria with fee-for-service criteria.

CHANGES TO RULE:

410-141-3960
Transportation: Member Reimbursed Mileage, Meals, and Lodging
(1) A Coordinated Care Organization (CCO) may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.¶
(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.¶
(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. The Oregon Health Plan (OHP) fee schedule is available on the Oregon Health Authorities (Authority's) website.¶
(4) The member must return any documentation a CCO requires before receiving reimbursement.¶
(5) A member must be reimbursed within fourteen (14) days after verifying the member's attendance of the appointment after the CCO receiving the reimbursement request.¶
(a) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10; or¶
(b) A CCO must issue the member a Notice of Adverse Benefit Determination, in accordance with requirements in OAR 410-141-3885, within fourteen (14) days if the member reimbursement is denied for any reason. If the member reimbursement request is incomplete the CCO shall take an additional fourteen (14) days to assist the member in completing the submission.¶
(6) A CCO shall reimburse members for meals when a member travels:¶
(a) For a minimum of four (4) hours round-trip; ~~or~~and¶
(b) The travel must span the following meal times:¶
(A) For a breakfast allowance, the travel must begin before 6:00 a.m.;¶
(B) For a lunch allowance, the travel must span the entire period from 11:30 a.m. through 1:30 p.m.; and¶
(C) For a dinner allowance, the travel must end after 6:30 p.m.¶
(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:¶
(a) A member would otherwise be required to begin travel before 5:00 a.m. in order to reach a scheduled appointment; or¶
(b) Travel from a scheduled appointment would end after 9:00 p.m.; or¶
(c) The member's health care provider documents a medical need.¶
(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.¶
(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:¶
(a) The member is a minor child and unable to travel without an attendant;¶
(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;¶
(c) The member is mentally or physically unable to reach their medical appointment without assistance; or¶
(d) The member is or would be unable to return home without assistance after the treatment or service.¶
(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCO's discretion.¶
(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:¶
(a) For mileage, meals, and lodging, and another resource also paid:¶
(A) The member; or¶
(B) The ride, meal, or lodging provider directly.¶
(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;¶
(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.¶
(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-5015

RULE SUMMARY: Update to reflect “Flexible Services” as new name for “Health-Related Services”.

CHANGES TO RULE:

410-141-5015
FINANCIAL SOLVENCY REGULATION: Financial Statement Reporting
(1) Financial reports to the Authority. A CCO shall submit the following to the Authority:¶
(a) On or before April 30 of each year, an unaudited financial statement for the 12-month period ending the 31st day of December immediately preceding;¶
(b) Unaudited quarterly financial statements each year according to the following schedule:¶
(A) On or before May 31 for the quarter ending the 31st day of March immediately preceding;¶
(B) On or before August 31 for the quarter ending the 30th day of June immediately preceding;¶
(C) On or before November 30 of each year for the quarter ending the 30th day of September immediately preceding.¶
(c) On or before June 30 of each year, an audited financial statement for the year ending the 31st of December immediately preceding.¶
(2) Except as otherwise allowed or required by the Authority, all annual and quarterly financial statements filed by a CCO with the Authority shall:¶
(a) Follow and be presented in accordance with Statutory Accounting Principles;¶
(b) Use a form established by the NAIC, including the instructions, and must complete the form according to the instructions:¶
(A) For the 2024 reporting year, on the annual statement approved for the 2024 reporting year by the NAIC, according to the applicable instructions published for that year by the NAIC;¶
(B) For the 2025 reporting year, on the annual statement approved for the 2025 reporting year by the NAIC, according to the applicable instructions published for that year by the NAIC;¶
(C) For the 2026 reporting year, on the annual statement approved for the 2026 reporting year by the NAIC, according to the applicable instructions published for that year by the NAIC;¶
(D) For the 2027 reporting year, on the annual statement approved for the 2027 reporting year by the NAIC, according to the applicable instructions published for that year by the NAIC.¶
(c) Be verified by the oaths of the president and secretary of the CCO or, in their absence, by two other duly authorized and acting principal officers; and¶
(d) Include the additional information listed in sections (4), (5) and (6) of this rule.¶
(3) Audited annual financial statements shall be subject to, and shall comply with, the requirements set forth in OAR 410-141-5020 through OAR 410-141-5040. Additional instructions for the filing of financial statements and reports are posted on the Authority's website at https://www.oregon.gov/oha/hsd/ohp/pages/cco-contract-forms.aspx.¶
(4) A CCO shall include the following as supplements to the CCO's quarterly and annual financial statement filings, using forms and templates prescribed by the Authority:¶
(a) An Annual Disclosure of Compensation Exhibit, disclosing the salary and benefits of the three officers or employees having the highest total compensation for the period. This exhibit shall be required only with the CCO's annual Exhibit L filing;¶
(b) A report of ~~Health-Related~~Flexible Services (as defined by OAR 410-141-3500 and 410-141-3845) and additional supplemental information, including care coordination, case management, ~~f~~and Flexible ~~s~~Services~~, and community benefit~~ expenses. CCOs shall comply with the following additional requirements regarding ~~Health-Related~~Flexible Services:¶
(A) ~~Health-Related~~Flexible Services shall be considered in the rate setting consistent with the State 1115 Waiver;¶
(B) ~~Health-Related~~Flexible Services shall be included as Activities that Improve Health Care Quality in the Minimum Medical Loss Ratio Rebate Calculation report.¶
(c) A certification of compliance with financial and encounter data reporting requirements;¶
(d) A report of third-party resources collections (CCO contractor);¶
(e) A report of Corporate Relationships of Contractors and Incentive Plan Disclosure and Detail (CCOs);¶
(f) CCO-specific utilization reports;¶
(g) Any other supplemental information deemed necessary by the Authority and specified in Exhibit L to the CCO Contract.¶
(5) A CCO shall report the following information in respect of the CCO's Restricted Reserve, using forms and templates prescribed by the Authority:¶
(a) Identification of custodians, account balances and assets comprising Restricted Reserve Funds held by a third-

party;¶
(b) A bank statement from each custodian of Restricted Reserve Funds of the account balance or aggregate fair market value of the assets comprising the Restricted Reserve Funds held by the custodian;¶
(c) Documentation of the liability that would be owed to creditors in the event of the CCO's insolvency;¶
(d) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.¶
(6) A CCO shall report the following information in respect of any Sub-Capitation Arrangements to which the CCO is a party, using forms and templates prescribed by the Authority:¶
(a) A CCO that sub-capitates any work described in its agreements with the Authority shall require the Sub-Capitated Counterparty to report financial information as specified in the CCO's agreements with the Authority;¶
(b) CCOs that make sub-capitation payments exceeding an annual amount defined by financial reporting instructions under the CCO Contract shall submit to the Authority on an annual basis the following financial reports with respect to each of the CCO's Sub-Capitated Counterparties:¶
(A) Statements of revenue, expenses and net income;¶
(B) Restricted Reserve Account documentation;¶
(C) Certification of compliance with financial and encounter data reporting requirements;¶
(D) Any supplemental information deemed necessary by the Authority.¶
(7) Following termination of the CCO Contract, the annual reports described in this rule are due for the last calendar year during which the CCO operated, and its quarterly reports are due until its last annual report has been filed.¶
(8) The CCO shall make such additional filings with the Authority as are required by the CCO's agreement with the Authority and as otherwise may be determined by the Authority from time to time to be necessary under the circumstances.
Statutory/Other Authority: ORS 413.042, ORS 414.572, 414.591, 414.605
Statutes/Other Implemented: ORS 414.570-414.686, ORS415.001-415.430

AMEND: 410-141-5285

RULE SUMMARY: Add definition for “Group Capital Calculation” per SB 831.

CHANGES TO RULE:

410-141-5285
CCO HOLDING COMPANY REGULATION: Definitions
Unless the context otherwise requires, as used in OAR 410-141-5225 to OAR 410-141-5355:¶
(1) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another person.¶
(2) "CCO holding company system" means two or more affiliated persons, one or more of which is a CCO, and includes a financial holding company as described in section 103 of the federal Gramm-Leach-Bliley Act (P.L. 106-102).¶
~~(a) "Person" means an individual, corporation, political subdivision, limited liability company, partnership, association, joint stock company, trust or unincorporated organization, or an entity or combination of entities similar to the entities described in this paragraph.¶~~
~~(b) "Person" does not include:¶~~
~~(A) A joint venture partnership that is engaged exclusively in owning, managing, leasing or developing real or tangible personal property; or¶~~
~~(B) For the purposes of OAR 410-141-5000 through 410-141-5355, a securities broker that holds, in the usual and customary broker's function, less than 20 percent of the voting securities of a CCO or of any person that controls.¶~~
(~~4~~3) "CCO subject to registration" means a CCO that is subject to the holding company registration requirements of OAR 410-141-5290.¶
(~~5~~4) "Control" means possessing the direct or indirect power to direct or cause the direction of the management and policies of a person whether by owning voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office the person holds.¶
(~~6~~5) "Enterprise risk" means an activity, circumstance, event or series of events that involve one or more of a CCO's affiliates and that, if not remedied promptly, are likely to have an adverse material effect on the CCO's or the CCO holding company system's financial condition or liquidity, including but not limited to an activity, circumstance, event or series of events that would cause the CCO's risk-based capital to fall into company action level or cause the Authority to determine that the CCO is in hazardous financial condition.¶
(~~7~~6) "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.¶
(~~8~~7) "Form A" means the form prescribed by OAR 410-141-5270.¶
(~~9~~8) "Form B" means the form prescribed by OAR 410-141-5300.¶
(~~10~~9) "Form C" means the form prescribed by OAR 410-141-5300.¶
(11~~0~~) "Form D" means the form prescribed by OAR 410-141-5320.¶
(12~~1~~) "Form F" means the form prescribed by OAR 410-141-5330.¶
(13~~2~~) "Group capital calculation" means a calculation made in accordance with instructions that the National Association of Insurance Commissioners publishes for the purpose of specifying the method of calculation. The director of the Department of Consumer and Business shall prescribe, on a periodic basis, the instructions published by the National Association of Insurance Commissioners. The director of the Department of Consumer and Business decision to prescribe the instructions for the method of calculation shall be posted on the Department of Consumer and Business's Division of Financial Regulation website at XXX.¶
(13) "Person" means an individual, corporation, political subdivision, limited liability company, partnership, association, joint stock company, trust or unincorporated organization, or an entity or combination of entities similar to the entities described in this paragraph. "Person" does not include:¶
(a) A joint venture partnership that is engaged exclusively in owning, managing, leasing or developing real or tangible personal property; or¶
(b) For the purposes of OAR 410-141-5000 through 410-141-5355, a securities broker that holds, in the usual and customary broker's function, less than 20 percent of the voting securities of a CCO or of any person that controls.¶
(14) "Political subdivision" has the meaning prescribed by OAR 410-141-5000.¶
(14~~5~~) "Security holder" means a person that owns a security of another person, including a security denominated as common stock, preferred stock, membership, or a debt obligation and any instrument that is convertible into or that is evidence of the right to acquire the security of another person.¶

(15~~6~~) "Subsidiary" means an affiliate that is controlled by a person directly or indirectly through one or more intermediaries.¶
(16~~7~~) "Ultimate controlling person" means a person that is not controlled by any other person. A CCO holding company system may have more than one ultimate controlling person.¶
(18) "Voting security" means a security that entitles the owner or holder of the security to vote at a meeting of shareholders or members, including a security that is convertible into a voting security or that is evidence of a right to acquire a voting security.¶
~~(17) "Ultimate controlling person" means a person that is not controlled by any other person. A CCO holding company system may have more than one ultimate controlling person.~~
Statutory/Other Authority: ORS 413.042, 414.572, 414.591, 414.605
Statutes/Other Implemented: ORS 414.570-414.686, 415.001-415.430

ADOPT: 410-141-5318

RULE SUMMARY: Refer CCOs subject to DCBS regulation to new reporting requirements regarding a group capital calculation per SB 831.

CHANGES TO RULE:

410-141-5318
CCO Holding Company Regulation: Group Capital Calculation
An insurance holding company system subject to the group capital calculation defined in Chapter 836 that includes a CCO, must include their CCO in their group capital calculation.
Statutory/Other Authority: ORS 413.042, 414.572, 414.591, 414.605
Statutes/Other Implemented: ORS 414.570-414.686, 415.001-415.430