OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

# NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

**FILED**
10/27/2023 2:11 PM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Add Health-Related Social Needs as a Covered Service to Align with 1115 Waiver

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2023 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.*

*A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.*

CONTACT: Nita Kumar
503-847-1357
hsd.rules@oha.oregon.gov

500 Summer St NE,
Salem,OR 97301

Filed By:
Nita Kumar
Rules Coordinator

## NEED FOR THE RULE(S)

The new rule includes Health Related Social Needs (HRSN) as a Medicaid Covered Service in Oregon, and outlines programmatic definitions and requirements. Changes to existing rules relate to adding HRSN Services as a Covered Service under Medicaid.

## DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

The Standard Terms and Conditions of the Oregon's amendment to its section 1115(a) demonstration titled "Oregon Health Plan" found at: https://www.medicaid.gov/sites/default/files/2023-04/or-health-plan-ca-04202023.pdf.
The HRSN Infrastructure and Services Protocol that outlines HRSN Services, found at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Attachment-J-DRAFT.pdf.

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

The inclusion of Health-Related Social Needs (HRSN) Services will advance racial equity in Oregon. OHA's mission of achieving health equity by 2030 references that health outcomes are a result of social determinants of health, which are the social and economic conditions that influence individual and group differences in health status. In other words, they are the non-medical factors that influence health outcomes. HRSN Services aim to directly influence these factors, by providing housing support, nutrition assistance, and climate devices to people who belong to populations that are experiencing a major life transition. These populations are disproportionally people of color, and include the following:
a. Youth with Special Health Care Needs (YSHCN) ages 19-26 as described in STC 4.6;
b. Adults and youth discharged from an Institute of Mental Disease;
c. Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities;
d. Youth involved in the child welfare system, including youth transitioning out of foster care;

e. Individuals transitioning from Medicaid-only to dual eligibility status;
f. Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; and
g. Individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon.

FISCAL AND ECONOMIC IMPACT:

The RAC did not identify any Fiscal or Economic Impact. The 1115 Medicaid waiver, upon which these OARs are based, allows for approximately $1 billion to be spent on HRSN Services.

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) There will be a cost of compliance on state agencies, including for staff to manage and implement the program throughout the 1115 Medicaid waiver, 2022-2027.
(2)
(a) OHA anticipates that the cost of compliance will fall primarily on OHA and the contracted entities that will manage HRSN Services on behalf of the State (e.g. Coordinated Care Organizations, third party contractors for Fee-for-Service). The cost of compliance is not currently known, but will be folded into the administrative fees of these contracts. It is not anticipated that the State will have direct contracts with small businesses at present.
(b) Same as (2)(a)
(c) Same as (2)(a)

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

OHA invited Coordinated Care Organizations and community-based organizations to the RAC.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-120-0000, 410-120-1160, 410-120-1210, 410-120-2000, 410-141-3515, 410-141-3525, 410-141-3530, 410-141-3570, 410-141-3585, 410-141-3820, 410-141-3835, 410-141-3850

AMEND: 410-120-0000

RULE SUMMARY: Adds HRSN Definitions to 410-120-0000.

CHANGES TO RULE:

410-120-0000
Acronyms and Definitions ¶

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3500 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division.¶
(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and

result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.¶
(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a CCO member, refer to OAR 410-141-3500.¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶
(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶
(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the OHP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶
(10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(11) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
(12) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(13) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(14) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶
(15) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), and federally recognized American Indian tribes).¶
(16) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with an MCE, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶
(17) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(18) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶
(19) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
(20) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶
(21) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶
(22) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(23) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶

(24) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
(25) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶
(26) "Atypical Provider" means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(27) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(28) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶
(29) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(30) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(31) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(32) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
(33) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(34) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
(35) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶
(36) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
(37) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(38) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.¶
(39) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶
(40) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶
(41) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.¶
(42) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(43) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶
(44) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(45) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(46) "Citizenship Waived Medical (CWM)" means Medicaid coverage for emergency medical needs (OAR 410-134-0003(1)) for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, expect they do not meet citizenship and/or non-citizen status requirements (OAR 410-

200-0240).¶
(47) "Claimant" means an individual who has requested a hearing.¶
(48) "Client" means an individual found eligible to receive OHP health services.¶
(49) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
(50) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(51) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(52) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(53) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(54) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they need;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(55) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
(56) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(57) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
(a) A client or member or their representative;¶
(b) A member of an MCE after resolution of the MCE's appeal process;¶
(c) An MCE member's provider; or¶
(d) An MCE.¶
(58) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
(59) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
(60) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.¶
(61) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶
(62) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
(63) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
(64) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:¶
(a) Ancillary services (OAR 410-120-0000(22));¶

(b) Diagnostic services necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition;¶
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k;¶
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver).¶
(65) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
(66) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
(67) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.¶
(68) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.¶
(69) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶
(70) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(71) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶
(72) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶
(73) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(74) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶
(75) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(76) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶
(77) "Dentally Appropriate" means health services, items, or dental supplies:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;¶
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply;¶
(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement;¶
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.¶
(78) "Department of Human Services (Department or DHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.¶
(79) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(80) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(81) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(82) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶

(83) "Division (Division)" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(84) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(85) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.¶
(86) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(87) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶
(88) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶
(89) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶
(90) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant person, the health of the persom or their unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.¶
(91) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.¶
(92) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶
(93) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation [sic] of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings.¶
(94) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information would result, or has resulted, in an overpayment.¶
(95) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or

~~otherwise limit family size.¶~~
~~(96) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:¶~~
~~(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;¶~~
~~(b) Is qualified to participate in 340B discount purchasing as an HTC;¶~~
~~(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has a identification number that is listed in the HTC directory on the CDC website;¶~~
~~(d) Is recognized by the Federal Regional Hemophilia Network that includes the state of Oregon; and¶~~
~~(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶~~
~~(97) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.¶~~
~~(98) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.¶~~
~~(99) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶~~
~~(100) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶~~
~~(101) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶~~
~~(102) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶~~
~~(103) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶~~
~~(104) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.¶~~
~~(105) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.¶~~
~~(106) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶~~
~~(107) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶~~
~~(108) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶~~
~~(109) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶~~
~~(110) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶~~
~~(111) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶~~
~~(112) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare~~

as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶
(113) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.¶
(114) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(115) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(116) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.¶
(117) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.¶
(118) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (division 42) report for the Division.¶
(119) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶
(120) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.¶
(121) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶
(122) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(123) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.¶
(124) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.¶
(125) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶
(126) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶
(127) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)¶
(128) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶

(129) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.¶
(130) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶
(131) "Joint fair hearing request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.¶
(132) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).¶
(133) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.¶
(134) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶
(135) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.¶
(136) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶
(137) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶
(a) "Long-term Care" as defined in OAR 461-001-0000 means 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 Behavioral Health, including state psychiatric hospitals;¶
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶
(138) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(139) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(140) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶
(141) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶
(142) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶
(143) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.¶

(144) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶
(145) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(146) "Medical Transportation" means transportation to or from covered medical services.¶
(147) "Medically Appropriate" means health services, items, or medical supplies that are:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;¶
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;¶
(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;¶
(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.¶
(148) "Medically Necessary" means health services and items that are required by a client or member to address one or more of the following:¶
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;¶
(b) The ability for a client or member to achieve age-appropriate growth and development;¶
(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;¶
(e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.¶
(149) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:¶
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and¶
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;¶
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.¶
(150) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(151) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.¶
(152) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
(153) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.¶
(154) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.¶
(155) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.¶

(156) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(157) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.¶
(158) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶
(c) OAR 410-141-3820 OHP Benefit Package of Covered Services;¶
(d) OAR 410-141-0520 Prioritized List of Health Services;¶
(e) OAR 410-134-0003 CWM Benefit Plans and State-Funded Supplemental Wraparound Services; and¶
(f) Any other applicable Division administrative rules.¶
(159) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.¶
(160) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(161) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶
(162) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶
(163) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶
(164) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(165) "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.¶
(166) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶
(167) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(168) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.¶
(169) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.¶
(170) "Oregon Health ID" means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.¶
(171) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.¶
(172) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶
(173) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(174) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶
(175) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.¶
(176) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:¶
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;¶

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.¶
(177) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.¶
(178) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(179) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.¶
(180) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.¶
(181) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.¶
(182) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶
(183) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.¶
(184) "Peer Support Specialist" including Family Support Specialist and Youth Support Specialist has the meaning given that term in OAR 410-180-0305.¶
(185) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶
(186) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and will assist the patient in achieving the goals.¶
(187) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(188) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶
(189) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(190) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶
(191) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(192) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶
(193) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶
(194) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶
(195) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(196) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶
(197) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(198) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(199) "Practitioner" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶
(200) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health

~~organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)¶~~
~~(201) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶~~
~~(202) "Primary Care Provider (PCP)" means any 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 initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶~~
~~(203) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶~~
~~(204) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶~~
~~(205) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.¶~~
~~(206) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶~~
~~(207) "Provider Organization" means a group practice, facility, or organization that is:¶~~
~~(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or¶~~
~~(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or¶~~
~~(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and¶~~
~~(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;¶~~
~~(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶~~
~~(208) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶~~
~~(209) "Public Health Clinic" means a clinic operated by a county government.¶~~
~~(210) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.¶~~
~~(211) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶~~
~~(212) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶~~
~~(213) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶~~
~~(214) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.¶~~
~~(215) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.¶~~
~~(216) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶~~
~~(217) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶~~
~~(218) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.¶~~

(219) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.¶
(220) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.¶
(221) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶
(222) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶
(223) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(224) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶
(225) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶
(226) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(227) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.¶
(228) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶
(229) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(230) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶
(231) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶
(232) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(233) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(234) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.¶
(235) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(236) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶
(237) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).¶
(238) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶

(239) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶
(240) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(241) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds will be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.¶
(242) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶
(243) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless:¶
(a) The exceptions cited in 42 CFR 1001.221 are met; or¶
(b) Otherwise stated by the Authority at the time of termination.¶
(244) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶
(245) "Transportation" means medical transportation.¶
(246) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶
(247) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(248) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶
(249) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶
(250) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(251) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(252) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶
(253) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.¶
(254) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶
(255) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).¶
(256) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(257) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(258) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of

~~the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.~~oordinated Care Organization (CCO) member, refer to OAR 410-141-3500.¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶
(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶
(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the Oregon Health Plan (OHP) 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶
(10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(11) "Adults and Youth Discharged from an Institution for Mental Disease (IMD)" means: ¶
(a) Members who have been discharged from an IMD (as such term is defined in 42 CFR 435.1010) within the last 12 months; or ¶
(b) Members who have been discharged from a qualifying non-IMD residential behavioral health program, with a primary discharge diagnosis of a mental health condition or substance use disorder, within the last 12 months. Qualifying non-IMD residential behavioral programs are acute care hospitals, alcohol detoxification centers if the length of stay has been at least 36hrs, emergency departments if the length of stay has been at least 36hrs, the Oregon State Hospital, psychiatric emergency services if the length of stay has been at least 36hrs, psychiatric residential treatment programs, residential substance use disorders and problem gambling treatment and recovery services, residential treatment homes, residential treatment facilities, secure child and adolescent inpatient psychiatric programs, secure residential treatment facilities, and subacute psychiatric programs. ¶
(c) Eligibility for HRSN services shall be determined within 12 months after discharge from an IMD or qualifying non-IMD, and such eligibility may be extended for up to an additional 12 months after such initial determination of eligibility for HRSN services.¶
(12) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, tribal correctional facilities, or immigration detention facilities. Eligibility for HRSN Services must be determined within 12 months after release from a carceral facility, and such eligibility may be extended for up to an additional 12 months after such initial determination of eligibility for HRSN services.¶
(13) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
(14) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(15) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(16) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶
(17) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, Area Agencies on Aging (AAAs), and federally recognized American Indian tribes).¶
(18) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with a Managed Care Entity (MCE), including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶

(19) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(20) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶
(21) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
(22) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶
(23) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶
(24) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(25) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(26) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
(27) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶
(28) "Area that is Experiencing Extreme Weather Events" means, as further defined in the HRSN Guidance Document, an area where a significant weather event, such as unusually high or low temperatures, wildfires, or compromised air quality, is (i) currently taking place as determined by a federal, state, local, or tribal government authority, or (ii) reasonably predicted to occur by a state or federal government authority having the authority or expertise to make such predictions, such as the National Weather Service.¶
(29) "At Risk of Homelessness" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.¶
(30) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(31) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(32) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶
(33) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(34) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(35) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(36) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
(37) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(38) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
(39) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶
(40) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
(41) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(42) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent

information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.¶
(43) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶
(44) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.(41) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon. OAR 950-060-0010(19)¶
(45) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(46) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶
(47) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(48) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(49) "Citizenship Waived Medical (CWM)" means Emergency-Only Health Benefits for individuals who prior to June 30, 2023, met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship or non-citizen status requirements (OAR 410-200-0240).¶
(50) "Claimant" means an individual who has requested a hearing.¶
(51) "Client" means an individual found eligible to receive OHP health services.¶
(52) "Climate-Related Supports" means climate-related devices and services provided to HRSN Eligible Members in their own home or non-institutional primary residence and for whom such equipment and support are Clinically Appropriate as a component of health services treatment or prevention. HRSN Eligible Members are only eligible for new climate-related devices every thirty-six (36) months, subject to paragraph b. below of this definition. ¶
(a) Clinically Appropriate climate-related devices for Member homes or non-institutional primary residence include: ¶
(A) Air conditioners for individuals at health risk due to significant heat; ¶
(B) Heaters for individuals at increased health risk due to significant cold;¶
(C) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;¶
(D) Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because existing refrigeration has inadequate temperature controls to meet their medication storage needs, etc.); or¶
(E) Portable power supplies for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs (PSPS) that may compromise their ability to use medically necessary devices.¶
(b) Climate-Related Support services include, as may be needed by the Member, the provision, service delivery, and installation of the devices identified above. In addition, HRSN climate device maintenance shall be comprised of the following:¶
(A) Air Filtration Devices (AFDs) - AFDs require replacement filters for effective air filtration. The rate at which filters need replacing is dependent on variables such as hours of use and the amount of smoke or other harmful particles in the air that require filtration. The initial device shall be delivered with no less than one additional replacement filter. Member request for additional air filter replacements shall be limited to three filter replacement fulfillments for the twelve (12) months following the delivery of the climate-related device, provided they do not become ineligible for Climate-Related Supports during such period. Subject to a Member being reassessed as eligible for Climate-Related Support Services at the end of each twelve (12) month period, the CCO or the Authority's Fee-for-Service Medicaid Program (FFS Program) (as applicable) must provide such Members with air filter replacements in accordance with the standard for the initial 12-month period following the delivery of the climate-related device.¶
(B) Device failure - If a covered device is damaged or defective upon arrival or fails to function properly within one year from the Member receiving their device, the manufacturer warranty shall be the first step towards a resolution. If either (i) the device is no longer within the manufacturer's warranty period, (or (ii) the warranty does not cover the necessary repairs, and the Member is still eligible for the climate-related device at the time the

climate-related device ceased to function properly, the CCO or FFS Program (as applicable) shall replace or repair the device at least once. Neither the CCO nor the FFS Program shall be required to repair or replace a climate-related device more than once when the climate-related device is outside the warranty period or the reason for failure is not covered by the warranty. ¶
(C) Warranty Process - The CCO or FFS Program (as applicable) shall support all Members with service call coordination or device replacement coordination for a period of twelve (12) months from the applicable Member receiving the device.¶
(D) Replacement Climate-Related Devices - In the event an HRSN Eligible Member advises Contractor that (i) their climate-related device was stolen, or (ii) they moved to a new residence without taking the climate-related device with them, the climate-related device may be replaced by Contractor subject to its reasonable discretion. However, in no event shall an HRSN Eligible Member be entitled to receive a replacement more than once during any thirty-six (36) month period.¶
(53) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
(54) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(55) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(56) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor. Clinically Appropriate includes not being solely for the convenience or preference of the Member or a provider of the service item or medical supply.¶
(57) "Closed Loop Referral" means the process of exchanging information between and among MCE, FFS Program, OHA, a Member, HRSN Service Providers, and other similar organizations, to make and communicate about the status of referrals for a Member's HRSN Services. A referral loop is considered to be closed once the referring organization is notified of the referral status of the referred Member. ¶
(58) "Community Information Exchange (CIE)" means a network of collaborative partners using technology for exchange of information to connect people to the services and supports they need. Functions must include Closed Loop Referrals, a shared resource directory, and consent.¶
(59) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(60) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(61) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they require;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(62) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.(56) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(63) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
(a) A client or member or their representative;¶

(b) A member of an MCE after resolution of the MCE's appeal process;¶
(c) An MCE member's provider; or¶
(d) An MCE.¶
(64) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
(65) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
(66) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.¶
(67) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶
(68) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
(69) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
(70) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:¶
(a) Ancillary Services OAR 410-120-0000 (22);¶
(b) Diagnostic Services OAR 410-120-0000 (82);¶
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations(CFR) 42 CFR part 438, subpart k;¶
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Waiver.¶
(71) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
(72) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
(73) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.¶
(74) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.¶
(75) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶
(76) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(77) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶
(78) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶
(79) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(80) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶
(81) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(82) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶
(83) "Dentally Appropriate" means health services, items, or dental supplies:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;¶
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply;¶

(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement;¶
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.¶
(84) "Department of Human Services (Department or DHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.¶
(85) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(86) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(87) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(88) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶
(89) "Division (Division)" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(90) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(91) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.¶
(92) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(93) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶
(94) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶
(95) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶
(96) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis, but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.¶
(97) "Emergency-Only Health Benefits" means Emergency Medical Conditions defined in OAR 410-134-0003(2)(a)(C)(i)(I-VIII) and OAR 410-134-0003(2)(b)(C)(ii) eligible for Medicaid match. (42 CFR 440.255)¶
(98) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.¶
(99) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶

(100) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.¶
(101) "Fee-for-Service (FFS)" means the non-risk payment method by which the Authority pays for OHP services provided to OHP Members who (i) are not enrolled in CCOs, or (ii) enrolled in a CCO but are receiving services carved out from the CCOs' contract with the Authority and are instead receiving services from a provider that has contracted directly with the Authority. ¶
(102) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an overpayment.¶
(103) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.¶
(104) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:¶
(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;¶
(b) Is qualified to participate in 340B discount purchasing as an HTC;¶
(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website;¶
(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and¶
(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶
(105) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.¶
(106) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.¶
(107) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶
(108) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶
(109) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(110) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶
(111) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(112) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.¶
(113) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's

Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The Division uses HCPCS codes; however, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.¶
(114) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶
(115) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶
(116) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶
(117) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶
(118) "Health Related Social Needs (HRSN)" Means the unmet climate related needs that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶
(119) "Healthier Oregon" means Emergency-Only Health Benefits defined OAR 410-120-0000(91) and State Funded Supplemental Health Benefits OAR 410-120-0000(238) provide benefits equal to OHP for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD or OSIPM Medical Program, except that they do not meet citizenship status requirements (OAR 410-200-0240 and 461-101-0010).¶
(120) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶
(121) "High Risk Clinical Need for Climate-Related Supports" means Members who do not live in a congregate care facility, community health facility, or other institutional setting and meet one or more of the following:¶
(a) Are age 65 or over, or ¶
(b) Are homebound; or ¶
(c) Need assistance with "Activities of Daily Living" as defined in OAR 411-015-0006 or "Instrumental Activities of Daily Living" as defined in OAR 411-015-0007 (ADL/IADL); or¶
Receive or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.¶
(d) Have one or more medical conditions that puts them at greater health risk due to weather events such as significant heat or cold, or poor air quality; or ¶
(e) Have a complex physical or behavioral health need; or ¶
(f) are pregnant; or ¶
(g) are up to 12 months postpartum; or ¶
(h) are less than six years of age.¶
(122) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶
(123) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶
(124) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.¶
(125) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(126) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(127) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in

providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.¶
(128) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.¶
(129) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division.¶
(130) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶
(131) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.¶
(132) "HRSN Clinical Risk Factors" means any one the following:¶
(a) Complex Behavioral Health Need: A Member has this HRSN Clinical Risk Factor if they have a persistent, disabling, progressive or life-thratening mental health condition or substance use disorder, which may or may not be diagnosed, that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.¶
(b) Developmental Disability Need: A Member has this HRSN Clinical Risk Factor if they have an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports for the individual to achieve and maintain care goals.¶
(c) Complex Physical Health Need:¶
(A) A Member with a persistent, disabling, progressive or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. ¶
(B) Examples include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders, or chronic immunosuppression. ¶
(d) Needs Assistance with ADLs/iADLs or Eligible for LTSS: Member has this HRSN Clinical Risk Factor if they:¶
(A) Need assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or ¶
(B) Receive or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.¶
(e) Interpersonal Violence Experience: A Member has this HRSN Clinical Risk Factor if they are experiencing or have experienced at any time in their life interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence.¶
(f) Repeated Emergency Department Use and Crisis Encounters:¶
(A) A Member with repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months);¶
(B) A Member with two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult or youth carceral setting; any length of stay in an emergency shelter; or any length of stay in emergency foster care.¶
(C) A Member who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months.¶
(g) Currently Pregnant or up to 12 months Postpartum;¶
(h) Children Less than 6 Years of Age;¶
(i) Adults 65 Years of Age or Older.¶
(133) "HRSN Connector" means the person, entity, or the Member, in the circumstance of self-referral, who assists the Member in documenting the information necessary to make a recommendation to the CCO or the FFS

Program for assessment for HRSN eligibility and authorization.¶
(134) "HRSN Covered Populations" means Members belonging to one or more of the following populations: ¶
(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD); ¶
(b) Adults and Youth Released from Incarceration; ¶
(c) Individuals involved in the Child Welfare system; ¶
(d) Individuals Transitioning to Dual Status; ¶
(e) Individuals who are HUD Homeless or At Risk of Homelessness, as such terms are defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; ¶
(f) Individuals with a High Risk Clinical Need for Climate-Related Supports in an Area Experiencing Extreme Weather Events.¶
(135) "HRSN Covered Services" means HRSN Services and HRSN Outreach and Engagement.¶
(136) "HRSN Eligible" means a Member who meets all of the following criteria: ¶
(a) Is OHP eligible and enrolled; ¶
(b) Belongs to one or more of the HRSN Covered Populations;¶
(c)Has at least one HRSN Clinical Risk Factor; ¶
(d) Has at least one HRSN Social Risk Factor; and ¶
(e) Meets any additional eligibility criteria and requirements that apply in connection with the specific HRSN Service. ¶
(137) "HRSN Fee Schedule" means the OHA document that identifies the reimbursement rates paid to HRSN Service Providers for HRSN Services furnished to HRSN Eligible Members who receive such services.¶
(138) "HRSN Outreach and Engagement" means: ¶
(a) Attempting to contact and engage Members who belong to one or more HRSN Covered Populations and who may be eligible for HRSN Services;¶
(b) Working with an HRSN Eligible Member through one or more contacts as is necessary to obtain the information necessary for conducting an assessment of the Member's HRSN Service need¶
(c) Determining whether the Member is enrolled in the Fee-for-Service (FFS) Program or a Coordinated Care Organization (CCO), and if a CCO which one.¶
(d) Transmitting partial or complete HRSN Recommendation information required for service authorization to the Member's CCO or to the FFS Program (or its designated third-party administrator) for eligibility determination and HRSN Service authorization; ¶
(e) Assisting HRSN Eligible Members in gaining access to other necessary medical, peer, social, educational, legal, and other services.¶
(139) "HRSN Recommendation" means a recommendation from an organization or individual to CCO or FFS Third Party Administrator in respect of a Member (which may or may not be the individual submitting the recommendation) requesting that CCO or FFS Third Party Administrator make a determination as to whether or not the Member is eligible for and authorized to receive one or more HRSN Service(s).¶
(140) "HRSN Self-Attestation" means a Member's attestation that they satisfy the applicable requirements necessary to establish the Member's eligibility to receive one or more HRSN Service(s) as indicated on a completed Eligibility and Service Needs Form submitted to CCO or FFS Third Party Administrator. ¶
(141) "HRSN Services" means Climate -Related Supports which address a Member's Health-Related Social Needs, as approved by CMS in the State 1115 Waiver. HRSN Services are Covered Services. In addition to the definitions, service descriptions and processes set forth in this Contract, additional information regarding the different components of HRSN Services are detailed in the HRSN Guidance Document. ¶
(142) "HRSN Service Provider" means a Provider, community organization, or other similar individual or entity that provides Climate-Related Supports or HRSN Outreach and Engagement Services, or both, to Members. ¶
(143) "HRSN Service Vendor" means any individual or entity that that is contracted or procured by a CCO, FFS Third Party Administrator, or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been assessed and approved to receive HRSN Services. Examples of HRSN Service Vendors include, without limitation, (i) entities or individuals that deliver air conditions, heaters, air filtration devices, portable power supplies, refrigeration units, or other similar portable devices to the homes or non-institutional primary residences of Members; (ii) entities or individuals that install, maintain, or repair air conditioners, heaters, air filtration devices, or other similar portable devices in Member homes or non-institutional primary residences.¶
(144) "HRSN Social Risk Factor" means the following: HRSN Device Needs, which means a Member has a need that will be aided by one of the following devices: air conditioners, heaters, air filtration devices, PPSs, and refrigeration units. ¶
(145) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.¶
(146) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health

Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶
(147) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(148) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.¶
(149) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.¶
(150) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶
(151) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶
(152) "Individuals Involved with Child Welfare" Members who are currently or have previously been involved in Oregon's Child Welfare System as more fully described in the HRSN Guidance Document.¶
(153) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in this HRSN Covered Population for the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 9 months after it takes effect. Eligibility for services must be determined within 9 months after transition to dual status and such eligibility may extend for up to 12 months after such determination.¶
(154) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)¶
(155) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶
(156) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.¶
(157) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶
(158) "Joint fair hearing request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.¶
(159) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).¶
(160) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.¶
(161) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶
(162) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.¶
(163) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients

with serious medical problems that require intense, special treatment for an extended period of time.¶
(164) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶
(a) "Long-term Care" as defined in OAR 461-001-0000 means 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 Behavioral Health, including state psychiatric hospitals;¶
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶
(165) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(166) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(167) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶
(168) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶
(169) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶
(170) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.¶
(171) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶
(172) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(173) "Medical Transportation" means transportation to or from covered medical services.¶
(174) "Medically Appropriate" means health services, items, or medical supplies that are:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;¶
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;¶
(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;¶
(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.¶
(175) "Medically Necessary" means health services and items that are required by a client or member to address one or more of the following:¶
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;¶
(b) The ability for a client or member to achieve age-appropriate growth and development;¶
(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;¶
(e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.¶

(176) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:¶
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and¶
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;¶
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.¶
(177) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(178) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under the age of 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.¶
(179) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
(180) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.¶
(181) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes.¶
(182) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.¶
(183) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(184) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.¶
(185) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶
(c) OAR 410-141-3820 OHP Benefit Package of Covered Services;¶
(d) OAR 410-141-0520 Prioritized List of Health Services; and¶
(e) Any other applicable Division administrative rules.¶
(186) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.¶
(187) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(188) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶
(189) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶
(190) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶
(191) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(192) "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.¶

(193) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶
(194) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(195) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.¶
(196) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.¶
(197) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.¶
(198) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.¶
(199) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶
(200) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(201) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶
(202) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.¶
(203) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:¶
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;¶
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.¶
(204) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.¶
(205) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(206) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.¶
(207) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.¶
(208) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.¶
(209) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶
(210) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.¶
(211) "Peer Support Specialist means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be:¶
(a) A self-identified individual currently or formerly receiving addictions or mental health services;¶
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;¶
(c) A self-identified individual in recovery from problem gambling.¶
OAR 950-060-0010(13)(a-c)¶
(212) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing

barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶
(213) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.¶
(214) "Person-Centered Service Plan" and "PCSP" means the HRSN-related component of the care plan that is developed in consultation with the Member upon HRSN Service authorization. The PCSP must be reviewed and revised upon reassessment of need at least every twelve (12) months, when the Member's circumstances or needs change significantly, or at the request of the Member.¶
(215) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(216) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶
(217) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(218) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶
(219) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(220) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶
(221) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶
(222) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶
(223) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(224) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶
(225) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(226) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(227) "Practitioner" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶
(228) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)¶
(229) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(230) "Primary Care Provider (PCP)" means any 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 initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶
(231) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶
(232) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶
(233) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.¶

(234) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶
(235) "Provider Organization" means a group practice, facility, or organization that is:¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;¶
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶
(236) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶
(237) "Public Health Clinic" means a clinic operated by a county government.¶
(238) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.¶
(239) "Public Safety Power Shutoff (PSPS)" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events that could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area.¶
(240) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶
(241) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶
(242) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶
(243) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.¶
(244) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.¶
(245) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶
(246) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶
(247) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.¶
(248) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.¶
(249) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.¶
(250) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶
(251) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶

(252) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(253) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶
(254) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶
(255) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(256) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.¶
(257) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶
(258) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(259) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶
(260) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶
(261) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(262) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(263) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.¶
(264) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(265) "State Funded Supplemental Health Benefits" means benefits defined in OAR 410-134-0003(2)(a)(C)(ii)(I-VII).¶
(266) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶
(267) "Subrogation" means right of the state to stand in place of the client in the collection of Third Party Resources (TPR).¶
(268) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶
(269) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶
(270) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(271) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds shall be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.¶
(272) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶
(273) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by

canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds shall be made for services provided after the date of termination. Termination is permanent unless:¶
(a) The exceptions cited in 42 CFR 1001.221 are met; or¶
(b) Otherwise stated by the Authority at the time of termination.¶
(274) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶
(275) "Transportation" means medical transportation.¶
(276) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶
(277) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(278) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶
(279) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶
(280) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(281) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(282) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶
(283) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.¶
(284) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶
(285) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).¶
(286) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(287) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(288) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-120-1160

RULE SUMMARY: Adds HRSN Services to the benefit package of health care services, Medical Assistance Benefits and Provider Rules.

CHANGES TO RULE:

410-120-1160
Medical Assistance Benefits and Provider Rules ¶

(1) Providers enrolled with and seeking reimbursement for services through the Health Systems Division (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) website for the Division and its medical assistance programs. It is the provider's responsibility to become familiar with and abide by these rules.¶
(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Health Services:¶
(a) Acupuncture services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);¶
(b) Administrative examinations as described in the Administrative Examinations and Billing Services program provider rules (OAR chapter 410, division 150);¶
(c) Substance Use Disorder treatment services:¶
(A) The Division covers ~~s~~Substance ~~u~~Use ~~d~~Disorder (SUD) inpatient treatment services for medically managed intensive inpatient detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate. The Division covers medically monitored detoxification and clinically managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered medically appropriate;¶
(B) The Division covers non-hospital SUD treatment and recovery services on a residential or outpatient basis. For information to access these services, contact the client's PHP or CCO if enrolled, the ~~c~~Community ~~m~~Mental ~~h~~Health ~~p~~Program (CMHP), an outpatient substance use disorder treatment provider, the residential treatment program, or the Addictions and Mental Health Division (AMH);¶
(C) The Division does not cover residential level of care provided in an inpatient hospital setting for substance use disorder treatment and recovery;¶
(d) Ambulatory surgical center services as described in the Medical-Surgical Services program provider rules (OAR 410, division 130);¶
(e) Anesthesia services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);¶
(f) Audiology services as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program provider rules (OAR chapter 410, division 129);¶
(g) Chiropractic services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);¶
(h) Clinical trials as described in these General Rules:¶
(A) Coverage includes routine patient costs for a beneficiary participating in a qualifying clinical trial or any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the items or services to the beneficiary are covered in the recipient's benefit package;¶
(B) "Qualifying clinical trial" is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition as described in section 1905(gg)(2)(A) of the Act;¶
(C) A qualifying clinical trial is a study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:¶
(i) The National Institutes of Health (NIH);¶
(ii) The Centers for Disease Control and Prevention (CDC);¶
(iii) The Agency for Health Care Research and Quality (AHRQ);¶
(iv) The Centers for Medicare & Medicaid Services (CMS);¶
(v) A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs;¶
(vi) A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;¶

(vii) A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:¶
(I) The Department of Energy;¶
(II) The Department of Veterans Affairs;¶
(III) The Department of Defense;¶
(viii) A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or¶
(ix) A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.¶
(D) Items and Services not included in clinical trial:¶
(i) Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial but is not included in the recipient's OHP benefit package;¶
(ii) Routine patient cost does not include any item or service that is provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the beneficiary and is not otherwise in the recipients OHP benefit package.(i) Dental services as described in the Dental Services program provider rules (OAR chapter 410, division 123);¶
(i) Early and ~~p~~Periodic ~~s~~Screening, ~~d~~Diagnosis, and ~~t~~Treatment services (EPSDT) are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;¶
(j) Family planning services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);¶
(k) Federally qualified health centers and rural health clinics as described in the Federally Qualified Health Centers and Rural Health Clinics program provider rules (OAR chapter 410, division 147);¶
(L) Home and community-based waiver services as described in the Authority and the Department's OARs of Child Welfare (CW), Self-Sufficiency Program (SSP), Addictions and Mental Health Division (AMH), and Aging and People with Disabilities Division (APD);¶
(m) Home enteral/parenteral nutrition and IV services as described in the Home Enteral/Parenteral Nutrition and IV Services program rules (OAR chapter 410, division 148) and related Durable Medical Equipment. Prosthetics, Orthotics and Supplies program rules (OAR chapter 410, division 122) and Pharmaceutical Services program rules (OAR chapter 410, division 121);¶
(n) Home health services as described in the Home Health Services program rules (OAR chapter 410, division 127);¶
(o) Hospice services as described in the Hospice Services program rules (OAR chapter 410, division 142);¶
(p) HRSN Services as described in the HRSN Services program rules (OAR 41-120-XXXX).¶
(q) Indian health services or tribal facility as described in The Indian Health Care Improvement Act and its amendments (Public Law 102-573), and the Division's American Indian/Alaska Native program rules (OAR chapter 410, division 146);¶
(~~q~~r) Inpatient hospital services as described in the Hospital Services program rules (OAR chapter 410, division 125);¶
(~~r~~s) Laboratory services as described in the Hospital Services program rules (OAR chapter 410, division 125) and the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~s~~t) Licensed direct-entry midwife services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~t~~u) Maternity case management as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~u~~v) Medical equipment and supplies as described in the Hospital Services program, Medical-Surgical Services program, DMEPOS program, Home Health Services program, Home Enteral/Parenteral Nutrition and IV Services program, and other rules;¶
(~~v~~w) When a client's benefit package includes mental health, the mental health services provided will be based on the Health Evidence Review Commission (HERC) Prioritized List of Health Services;¶
(~~w~~x) Naturopathic services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~x~~y) Nutritional counseling as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~y~~z) Occupational therapy as described in the Physical and Occupational Therapy Services program rules (OAR

chapter 410, division 131);¶
(~~z~~aa) Organ transplant services as described in the Transplant Services program rules (OAR chapter 410, division 124);¶
(~~aa~~bb) Outpatient hospital services including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital as described in the Hospital Services program rules (OAR chapter 410, division 125);¶
(~~bb~~cc) Physician, podiatrist, nurse practitioner and licensed physician assistant services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
(~~cc~~dd) Physical therapy as described in the Physical and Occupational Therapy and the Hospital Services program rules (OAR chapter 410, division 131 and 125);¶
(~~dd~~ee) Post-hospital extended care benefit as described in OAR chapter 410, division 120 and 141 and Aging and People with Disabilities (APD) program rules;¶
(~~ee~~ff) Prescription drugs including home enteral and parenteral nutritional services and home intravenous services as described in the Pharmaceutical Services program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services program (OAR chapter 410, division 148), and the Hospital Services program rules (OAR chapter 410, division 125);¶
(~~ff~~gg) Preventive services as described in the Medical-Surgical Services program (OAR chapter 410, division 130), the Dental Services program rules (OAR chapter 410, division 123), and prevention guidelines associated with the Health Evidence Review Commission's Prioritized List of Health Services (OAR 410-141-0520);¶
(~~gg~~hh) Private duty nursing as described in the Private Duty Nursing Services program rules (OAR chapter 410, division 132);¶
(~~hh~~ii) Radiology and imaging services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130), the Hospital Services program rules (OAR chapter 410, division 125), and Dental Services program rules (OAR chapter 410, division 123);¶
(~~ii~~jj) Rural health clinic services as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);¶
(~~jj~~kk) School-based health services as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);¶
(~~kk~~LL) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program rules (OAR chapter 410, division 129) and Hospital Services program rules (OAR chapter 410, division 125);¶
(~~LL~~mm) Transportation necessary to access a covered medical service or item as described in the Medical Transportation program rules (OAR chapter 410, division 136);¶
(~~mm~~nn) Vision services as described in the Visual Services program rules (OAR chapter 410, division 140).¶
(3) Other Authority or Department, divisions, units, or offices, including Vocational Rehabilitation, AMH, and APD may offer services to Medicaid eligible clients, that are not reimbursed by or available through the Division of Medical Assistance Programs.¶
~~[Publications: Publications referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1210

RULE SUMMARY: Adds HRSN Services to Medical Assistance Benefit Packages and Delivery System coverage.

CHANGES TO RULE:

410-120-1210
Medical Assistance Benefit Packages and Delivery System ¶

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.¶
(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules.¶
(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.¶
(4) Benefit package descriptions:¶
(a) Oregon Health Plan (OHP) Plus:¶
(A) Benefit package identifier: BMH;¶
(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if they are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;¶
(C) Coverage includes:¶
(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);¶
(ii) Ancillary services, (OAR 410-141-3820);¶
(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;¶
(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;¶
(v) Hospice;¶
(vi) Post-hospital extended care benefit up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO; and¶
(vii) HRSN Services (OAR 410-120-2000).¶
(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):¶
(i) Selected dental (OAR chapter 410, division 123 and 200);¶
(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).¶
(b) OHP with Limited Drugs:¶
(A) Benefit package identifier: BMM, BMD;¶
(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;¶
(C) Coverage includes: Services covered by Medicare and OHP Plus as described in this rule;¶
(D) Limitations:¶
(i) The same as OHP Plus as described in this rule;¶
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:¶
(I) Over-the-counter (OTC) drugs;¶
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D ~~wi~~shall cover those indications).¶
(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;¶
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;¶
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.¶
(c) Qualified Medicare Beneficiary (QMB)-Only:¶

(A) Benefit Package identifier code MED;¶
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;¶
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;¶
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;¶
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.¶
(d) Citizenship Waived Medical (CWM): Benefit package ~~and supplemental benefits, refer to OAR 410-134-0003~~defined in OAR 410-134-0005(2), ending June 30, 2023. Refer to OAR 410-134-0005(3) for billing guidance.¶
(e) Compact of Free Association (COFA) Dental Program:¶
(A) Benefit Package identifier code ~~XXX~~DEN;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of Dental services that the ~~a~~Authority determines ~~wi~~shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(f) Veteran Dental Program:¶
(A) Benefit Package identifier code ~~XXX~~DEN and DNT;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of dental services that the ~~a~~Authority determines ~~wi~~shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(5) Division clients are enrolled for covered health services and HRSN Services to be delivered through one of the following means:¶
(a) Coordinated Care Organization (CCO):¶
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;¶
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services ~~or,~~ dental care, or HRSN Services.¶
(b) Fee-for-service (FFS):¶
(A) These clients are not enrolled in a CCO;¶
(B) Subject to limitations and restrictions in the Division's individual program rules, the client ~~can~~may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.¶
(C) Delivery of HRSN services for members enrolled in FFS shall be provided as set forth in OAR 410-120-2000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690

ADOPT: 410-120-2000

RULE SUMMARY: Outlines Health-Related Social Needs (HRSN) Services as a Medicaid Covered Service, outlining programmatic requirements.

CHANGES TO RULE:

410-120-2000
HRSN SERVICES DELIVERY
(1) The purpose of this rule is to establish the processes, standards, and obligations required to be followed or met in administering and delivering HRSN Services.¶
(2) Notice of Availability of HRSN Services. The MCE or FFS HRSN Third Party Administrator (TPA) shall inform all Members that HRSN Services are Covered Services consistent with the State 1115 Waiver, using National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards.¶
(3) Identifying Members of HRSN Covered Populations. The MCE or Fee-For-Service (FFS) HRSN third party administrator (FFS HRSN TPA) shall, at the Authority's direction, ensure multiple pathways for Members to be identified as potentially eligible for HRSN Services. Pathways must include:¶
(a) Proactively identifying Members through a review of the MCE or FFS HRSN third party administrator's encounter and claims data; ¶
(b) Engaging HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members; ¶
(C) Receiving HRSN Recommendations from other entities and individuals; and ¶
(d) Accepting the Members' self-referrals. ¶
(4) Screening Members for HRSN Eligibility.¶
(a) The MCE and FFS HRSN TPA shall make good faith effort that all Members identified as potentially eligible for HRSN Services through required pathways are offered screening for HRSN Social Risk Factors and ¶
(b) if an HRSN Service need is identified as a result of such screening, the MCE or FFS HRSN TPA or HRSN Service Provider shall collect information to determine HRSN Eligibility from the MCE or FFS HRSN TPA data, HRSN Connector or the Member. ¶
(c) The MCE or FFS HRSN third party administrator must accept the screening tools used by the HRSN Connector instead of requiring their own template, provided the HRSN Connector's screening tools meet all the HRSN screening requirements. ¶
(d) The MCE or FFS HRSN third party administrator must also accept, but not require, the standard screening template provided by the state ¶
(e) If the potentially eligible individual is not a Member of the OHP, the MCE or FFS HRSN third party administrator shall connect individuals to resources to determine OHP Eligibility as requested by the Member or as may otherwise be appropriate.¶
(5) HRSN Eligibility. The MCE or FFS HRSN TPA must compile all necessary eligibility information to determine whether the Member is HRSN Eligible. Contractor must document attempts to collect information needed to determine eligibility. The MCE or FFS HRSN TPA must accept or deny a Member's HRSN Self-Attestation for eligibility and authorization for one or more applicable HRSN Service(s).¶
(6) Authorization HRSN Services. The MCE or FFS HRSN TPA shall:¶
(a) Verify the Member's eligibility for HRSN Services: For Members who satisfy conditions of HRSN Eligibility, are an OHP Member, and have an HRSN Service need, the MCE or FFS HRSN third party administrator shall authorize HRSN Services that are Clinically Appropriate. ¶
(b) The Authorization should include service duration, as appropriate, not to exceed 12 months for an initial authorization.¶
(c) Contractor shall attempt to ensure they do not knowingly authorize an HRSN service that is duplicative of a state or federally funded service or other HRSN Service the Member is already receiving.¶
(d) Document the approval or denial of HRSN Services; ¶
(A) Contractor is required to notify the Member of the approval or denial of HRSN Services, and follow the Grievance and Appeal process.¶
(B) Denial shall be based on the Member not meeting all HRSN Eligible criteria to authorize specific HRSN Service.¶
(e) If the HRSN Eligible Member is authorized for an HRSN Service, then the MCE or FFS HRSN TPA must refer the Member to an HRSN Service Provider that provides the Member's HRSN Service need. The referral must be made through a Closed Loop Referral.¶
(A) The MCE or FFS HRSN TPA must, to the extent capacity permits, support the Member's choice of HRSN Service Provider ¶
(B) Find and refer the Member to alternative HRSN Service Providers if needed and available;¶

(C) Inform the Member they have the option to opt out of technology, like CIE, and still receive HRSN Services; and¶
(D) Ensure and document the Member's HRSN Service needs are being and have been met by the HRSN Service Provider per the Member's Person-Centered Service Plan.¶
(7) Confirmation of Climate-Related Supports Required. Prior to making a Closed Loop Referral, the MCE or the FFS HRSN TPA must determine availability of the Climate-Related Supports (either devices or any necessary installation or other related service supports, or both) and notify the Member authorized for the Climate Supports services of anticipated availability date. If for any reason there is limited availability of either devices or necessary installation or other related service supports, the MCE or FFS HRSN TPA shall notify the State of the limitations, the reason for the limitation, and its plan to obtain additional equivalent devices or related service supports or both.¶
(8) No Subcontracting or Delegation of HRSN Service Authorization and Planning. The MCE or FFS HRSN third party administrator shall not subcontract or otherwise Delegate the responsibility for HRSN Service authorization or service planning to an HRSN Service Provider.¶
(9) Person-Centered Service Plan (PCSP):¶
(a) Care Coordination shall be documented and managed through the Member's Care Plan.¶
(b) Upon the MCE or FFS HRSN TPA's authorization of HRSN Services, the MCE or FFS HRSN TPA and the Member shall update the Member's Care Plan as outlined in OAR 410-141-3870 to include an HRSN PCSP for authorized the HRSN Service(s). ¶
(A) The HRSN PCSP shall be in writing and developed with and agreed upon by the Member, the Member's guardian, or both, as applicable. The HRSN PCSP must include all of the following: ¶
(i) The recommended HRSN Service(s);¶
(ii) The authorized HRSN Service duration;¶
(iii) The HRSN Service Provider;¶
(iv) The goals of the HRSN Service(s);¶
(v) The anticipated follow-up and transition plan;¶
(B) The MCE or FFS HRSN TPA shall, at a minimum, have as many meetings as may be necessary to develop the PCSP, but in no event less than one meeting with the Member (or the Member's guardian, or both, as applicable) during development of the PCSP. The meeting with the Member may be held in person, by telephone, or via videoconference. If efforts to have a meeting are unsuccessful, or if the Member declines participation, the MCE or FFS HRSN TPA shall document their attempts and barriers to having a meeting, and justification for continued provision of HRSN Service.¶
(C) A parent, guardian, or caregiver of a child may receive an HRSN Service on the child's behalf if the parent, guardian, or caregiver lives with the child and it is in the best interest of the child as determined through the PSCP.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented:

AMEND: 410-141-3515

RULE SUMMARY: Clarifies that HRSN Services must be available in all service areas.

CHANGES TO RULE:

410-141-3515
Network Adequacy
(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate will become enrolled as members.¶
(2) The MCE shall develop a provider network that enables members to access services within the standards defined in this rule.¶
(3) The MCE shall meet access-to-care standards that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.¶
(4) MCEs shall meet quantitative network access standards defined in rule and contract.¶
(5) MCEs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.¶
(6) In developing its provider network, the MCEs shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health conditions, in the most appropriate and independent setting, including in their own home or independent supported living.¶
(7) All MCEs shall ensure 95% of members can access providers within acceptable travel time or distance requirements.¶
(a) MCEs shall ensure all members can access the following provider and facility types within acceptable travel time or distance:¶
(A) Mental health providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(B) Dental services providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(C) Specialty providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(D) Substance use disorder providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(E) Primary care providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(F) Patient Centered Primary Care Homes;¶
(G) Federally Qualified Health Centers;¶
(H) Hospital;¶
(I) Hospital, acute psychiatric care;¶
(J) Rural Health Centers;¶
(K) Pharmacies;¶
(L) Post-hospital skilled nursing facilities;¶
(M) Urgent Care Centers;¶
(N) Additional provider types when it promotes the objectives of the Authority.¶
(b) All "MCEs" acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications. Time and distance standards may not exceed the following, unless otherwise approved by the Authority:¶
(A) In urban areas, 30 miles, or 30 minutes;¶
(B) In rural areas, 60 miles, or 60 minutes.¶
(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:¶
(a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;¶
(b) The number and types of providers required to furnish the contracted services and the number and types of providers actively providing services within the MCE's current provider network;¶
(c) How the MCE will meet the accommodation and language needs of individuals with LEP as defined in OAR 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the

Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;¶
(d) The availability of telemedicine within the MCE's contracted provider network.¶
(9) MCEs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.¶
(10) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or Oregon Youth Authority (OYA) services have access to primary care, oral care (when the MCE is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. MCEs shall monitor and have policies and procedures to ensure:¶
(a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;¶
(b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.¶
(11) MCEs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:¶
(a) Physical health:¶
(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;¶
(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;¶
(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.¶
(b) Oral and Dental care for children and non-pregnant individuals:¶
(A) Dental Emergency services as defined in OAR 410-120-0000: Seen or treated within 24 hours;¶
(B) Urgent dental l care: Within two weeks;¶
(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.¶
(c) Oral and Dental care for pregnant individuals:¶
(A) Dental Emergency services. Seen or treated within 24 hours;¶
(B) Urgent dental care, within one week;¶
(C) {Routine oral care: Within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate.¶
(d) Behavioral health:¶
(A) Urgent behavioral health care for all populations: Within 24 hours;¶
(B) Specialty behavioral health care for priority populations:¶
(i) In accordance with the timeframes listed in this rule for assessment and entry, terms are defined in OAR 309-019-0105, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;¶
(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;¶
(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;¶
(iv) Opioid use disorder: Assessment and entry within 72 hours;¶
(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;¶
(vi) Children with serious emotional disturbance as defined in OAR 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.¶
(C) Routine behavioral health care for non-priority populations: Assessment within seven days of the request, with

a second appointment occurring as clinically appropriate.¶
(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who have Limited English Proficiency, living in a household where there is no adult available to communicate in English or there is no telephone:¶
(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives;¶
(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical health, behavioral health, or dental services visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members;¶
(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;¶
(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCEs shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language; and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;¶
(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;¶
(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;¶
(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:¶
(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;¶
(B) MCEs shall collect and report language access and interpreter services to the Authority quarterly using the report form provided by the Authority. The quarterly due date for each Report is the first day of each calendar quarter, reporting data for the twelve (12) months ending one quarter before the due date. The first such twelve-month Report is due by April 1, 2022, for the twelve-month period from January 1, 2021, through December 31, 2021;¶
(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.¶
(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. MCEs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.¶
(14) MCEs must submit a Delivery System Network (DSN) report annually to the Authority that includes access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:¶
(a) Behavioral health access;¶
(b) Interpreter utilization by the MCE's provider network;¶
(c) Behavioral health provider network.¶
(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).¶
(16) MCEs shall implement and require its providers to adhere to the following appointment and wait time requirements:¶
(a) A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;¶

(b) MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:¶
(A) Timely rescheduling of missed appointments, as deemed medically appropriate;¶
(B) Documentation in the clinical record or non-clinical record of missed appointments;¶
(C) Recall or notification efforts; and¶
(D) Method of member follow-up.¶
(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, MCEs shall provide outreach services as medically appropriate;¶
(d) Recognition of whether NEMT services were the cause of the member's missed appointment.¶
(17) MCEs shall assess the needs of their membership and make available supported employment and Assertive Community Treatment services when members are referred and eligible:¶
(a) MCEs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by the Authority. When no appropriate provider is available, the MCE shall consult with the Authority and develop an approved plan to make supported employment and Assertive Community Treatment (ACT) services available;¶
(b) If 10 or more members in a MCE region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive ACT for more than 30 days, MCEs shall take action to reduce the waitlist and serve those individuals by:¶
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or¶
(B) Adding additional Assertive Community Treatment teams; or¶
(C) When no appropriate ACT provider is available, the MCE shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.¶
(18) HRSN Service Provider Minimum Network Requirements. An MCE must offer HRSN Services in all service areas in which the MCE operates. The MCE must ensure that HRSN Services are delivered to Members in a timely manner.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3525

RULE SUMMARY: Adds HRSN to Outcome and Quality Measures

CHANGES TO RULE:

410-141-3525
Outcome and Quality Measures
~~Outcome and Quality Measures~~¶
(1) 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 will 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 not typically associated with medical care. Transformational metrics will 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 will 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 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: 410-141-3530

RULE SUMMARY: Clarifies HRSN expectations with regards to sanctions.

CHANGES TO RULE:

410-141-3530
Sanctions
(1) The Authority may establish and impose sanctions on MCEs, pursuant to 42 CFR  438.700, if the Authority makes a determination specified in paragraph (3) of this rule.¶
(2) The Authority may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.¶
(3) The Authority may impose sanctions if the Authority determines that an MCE acts or fails to act as follows:¶
(a) Fails substantially to provide medically necessary services required under law or under its contract with the Authority to an enrollee covered under the contract~~;~~.¶
(b) Imposes on enrollee's premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;¶
(c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;¶
(d) Misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services (CMS) or to the Authority;¶
(e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee,~~ or~~ health care provider, or HRSN Service Provider;¶
(f) Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR  422.208 and 422.210;¶
(g) Distributes directly or indirectly through any agent or independent contractor marketing materials that are not approved by the Authority or that contain false or materially misleading information;¶
(h) Violates any of the other applicable requirements of state or federal Medicaid law; or¶
(i) Fails to comply with any legal or contractual requirements that, pursuant to the MCE contract, may form a basis for sanctions.¶
(4) The Authority may impose a range of sanctions under this rule including the following:¶
(a) Civil monetary penalties in the amounts specified in section (5) of this rule;¶
(b) Appointment of temporary management for an MCE as permitted under 42 CFR 438.706;¶
(c) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;¶
(d) Suspension of all new enrollment, including default enrollment, after the date the Authority notifies the MCE of a determination of a violation of rule or contract requirements;¶
(e) Suspension of payment for members enrolled after the effective date of the sanction and until the Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;¶
(f) Additional sanctions available under Oregon Revised Statutes and Oregon Administrative Rules that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance.¶
(5) If the Authority imposes civil monetary penalties:¶
(a) The maximum civil monetary penalty the Authority may impose varies depending on the nature of the MCE's action or failure to act, subject to the limits in 42 CFR  438.704;¶
(b) The Authority may issue penalties as specified on a per event, per member impacted, or per day basis for the duration of noncompliance.¶
(6) Before imposing any sanctions, the Authority must give the affected MCE timely written notice that explains the following:¶
(a) The basis and nature of the sanction;¶
(b) Any appeal rights under this rule and any other appeal rights that the Authority elects to provide.¶
(7) Administrative review, and if requested mediation:¶
(a) Are available for review of sanction decisions in accordance with OAR 410-120-1580 and 410-141-3550;¶
(b) If the Authority determines that there is continued egregious behavior, or that such action is necessary to ensure the health or safety of members, the Authority may impose the sanction before an administrative review opportunity is provided.¶
(8) Before terminating an MCE's contract for cause, the Authority must provide the MCE the opportunity for a pre-termination hearing. The Authority must do all of the following:¶
(a) Give the MCE written notice of its intent to terminate, the reason for termination, and the time and place of the

hearing;¶
(b) After the hearing, give the MCE written notice of the decision affirming or reversing the proposed termination of the contract and for an affirming decision the effective date of termination;¶
(c) For an affirming decision, give enrollees of the MCE notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-141-3570

RULE SUMMARY: Adds HRSN to Managed Care Entity Encounter Claims Data Reporting

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, and HRSN Services 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: 410-141-3585

RULE SUMMARY: Adds HRSN to MCE Member Relations: Education and informationrequirements

CHANGES TO RULE:

410-141-3585
MCE Member Relations: Education and Information
(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE or its subcontractors and providers that:¶
(a) Is intended solely for members; and¶
(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.¶
(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. MCEs shall address health literacy issues by preparing these documents at a low literacy reading level, incorporating graphics and utilizing alternate formats.¶
(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's coordinated care model. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.¶
(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:¶
(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Intensive Care Coordination (ICC) Services, and where applicable for Full Benefit Dual Eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;¶
(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305 and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10;¶
(c) Inform all members of the availability of Ombudsperson services.;¶
(5) Written member materials shall comply with the following language and access requirements:¶
(a) Materials shall be translated in the prevalent non-English languages as defined in OAR 410-141-3575 in the service area as well as include a tagline in large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;¶
(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings;¶
(c) Electronic versions of member materials shall be made available on the MCE website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the MCE shall provide it upon request within five business days.¶
(6) MCE provider directories shall be a single, comprehensive resource that encompasses the MCE's entire Provider Network, including any Providers contracted by Subcontractors that serve the MCE's Members. MCEs may not utilize a Subcontractor's separate or standalone provider directory to meet the Provider Directory requirement and shall include:¶
(a) The provider's name as well as any group affiliation;¶
(b) Street address(es);¶
(c) Telephone number(s);¶

(d) Website URL, as appropriate;¶
(e) Provider Specialty, as appropriate;¶
(f) Whether the provider will accept new members;¶
(g) Whether the provider offers both telehealth and in-person appointments;¶
(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, (including languages (including American Sign Language) offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;¶
(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶
(j) Narrative space that is optional for providers to list biographical, cultural, linguistic, or other relevant information.¶
(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of provider's offices, exam rooms, restrooms, and equipment.¶
(L) The information for each of the following provider types covered under the contract, as applicable to the MCE contract:¶
(A) Physicians, including specialists;¶
(B) Hospitals;¶
(C) Pharmacies;¶
(D) Behavioral health providers; including specifying substance use treatment providers;¶
(E) Dental providers;¶
(F) HRSN Service Providers.¶
(m) Information included in the provider directory shall be updated at least monthly, and electronic provider directories shall be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format.¶
(7) Each MCE shall make available in electronic or paper form the following information about its formulary:¶
(a) Which medications are covered both generic and name brand;¶
(b) What tier each medication is on.¶
(8)-Within 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.¶
(9) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.¶
(10) MCEs must notify enrollees:¶
(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages as defined in OAR 410-141-3575 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille;¶
(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;¶
(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.¶
(11) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory.¶
(12) MCE Member Handbooks shall comply with the Authority's formatting and readability standards and contain all elements outlined in the Member Handbook Evaluation Criteria issued by the Authority in accordance with the requirements described in Exhibit B, Part 3, Section 5 of the Contract.¶
(13) Member health education shall include:¶
(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;¶
(b) Information specifying that MCEs shall not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:¶
(A) The member's health status, medical care, or treatment options, including any alternative treatment that may

be self-administered;¶
(B) Any information the member needs to decide among all relevant treatment options;¶
(C) The risks, benefits, and consequences of treatment or non-treatment.¶
(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;¶
(d) An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;¶
(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;¶
(f) MCEs shall provide written notice to affected members of any Material Changes to Delivery System as defined in OAR 410-141-3500 or any other significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or within 15 calendar days after receipt or issuance of the termination notice if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.¶
(14) MCEs shall provide an identification card to members, unless waived by the Authority, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCE, members, and providers.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3820

RULE SUMMARY: Added HRSN as a Covered Service

CHANGES TO RULE:

410-141-3820
Covered Services
(1) General standard. The OHP Benefit Package includes treatments and health services which pair together with a condition on the same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified in any relevant Statements of Intent and Guideline Notes of the Prioritized List of Health Services. The Benefit Package also covers the additional services described in this rule.¶
(a) As used in OAR 410-141-3820 and 410-141-3825, the word "health services" has the meaning given in ORS 414.025(13);¶
(b) Services are covered with respect to an individual member only when the services are medically or orally necessary and appropriate as defined in 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ORS 743A.012.¶
(c) HRSN Services are covered with respect to an individual member only when the HRSN Services are appropriate and relevant to Clinical Risk Factors and Social Risk Factors as defined in OAR 410-120-XXXX;¶
(~~c~~d) Benefit Package coverage of prescription drugs is discussed in OAR 410-141-3855;¶
(~~d~~e) The Benefit Package is subject to the exclusions and limitations described in OAR 410-141-3825.¶
(2) MCE service offerings:¶
(a) MCEs shall offer their members, at a minimum:¶
(A) The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the MCE's mandatory scope of services; and¶
(B) Any additional services required in OAR chapter 410, or in the MCE contract.¶
(b) CCOs shall coordinate physical health, behavioral health ~~and~~, oral health care benefits, and HRSN benefits;¶
(c) With respect to members who are dually eligible for Medicare and Medicaid, MCEs shall provide:¶
(A) OHP Benefit Package services except for Medicaid-funded long-term care, services, and supports; and¶
(B) Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan as specified in 410-141-3565 and specific to benefit packages in OAR 410-120-1210.¶
(3) Diagnostic services. Diagnostic services that are medically or orally appropriate and medically or orally necessary to diagnose the member's presenting condition (signs and symptoms) or guide management of a member's condition, regardless of whether the condition appears above or below the funded line on the Prioritized List of Health Services. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines on the Prioritized List of Health Services.¶
(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.¶
(5) Preventive services. Preventive Services are included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, as specified in related guideline notes. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.¶
(6) Ancillary services. Ancillary services are covered subject to the service limitations of the OHP program rules when:¶
(a) The services are medically or orally necessary and appropriate in order to provide a funded service; or¶
(b) The provision of ancillary services will enable the member to retain or attain the capability for independence or self-care;¶
(c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines on the Prioritized List of Health Services.¶
(7) SUD services. The provision of SUD services shall comply with OAR 410-141-3545.¶
(8) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k.¶
(9) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in 410-130-0245.¶
(10) Services necessary for compliance with the requirements for HRSN Services (as described in Oregon's Medicaid 1115 Waiver for 2022-2027) and meeting requirements for individualized determination of Service authorization as specified in OAR 410-XXX-XXXX.¶
(11) Coverage of services for unfunded conditions based on effect on funded comorbid conditions:¶

(a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:¶
(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and¶
(B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and¶
(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.¶
(b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (10);¶
(c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis;¶
(d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:¶
(A) Treating health care provider opinion;¶
(B) Medical research; and¶
(C) Current peer review.¶
(11~~2~~2) Ensuring that all coverage options are considered:¶
(a) When a provider receives a denial for a non-covered service for any member, especially a member with a disability or with a co-morbid condition, the provider shall determine whether there may be a medically appropriate covered service to address the member's condition or clinical situation, before declining to provide the non-covered service. The provider's determination shall include consideration of whether a service for an unfunded condition may improve a funded comorbid condition under subsection (10);¶
(b) If a member seeks, or is recommended, a non-covered service, providers shall ensure that the member is informed of:¶
(A) Clinically appropriate treatment that may exist, whether covered or not;¶
(B) Community resources that may be willing to provide the relevant non-covered service;¶
(C)-If appropriate, future health indicators that would warrant a repeat evaluation visit.¶
(c) Before an MCE denies coverage for an unfunded service for any member, especially a member with a disability or with a co-morbid condition, the MCE shall determine whether the member has a funded condition or condition/treatment pair that would entitle the member to coverage under the program.¶
(12~~3~~3) Assistance to providers. The Authority shall maintain a telephone information line for the purpose of assisting practitioners in determining coverage under the OHP Benefit Package. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Authority shall make a retrospective determination under this section, provided the Authority is notified of the emergency situation during the next business day. If the Authority denies a requested service, the Authority shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.¶
(13~~4~~4) Ad hoc coverage determinations.¶
(a) When a member requests a hearing pertaining to a funded condition and a funded or unfunded treatment that does not pair on the HERC Prioritized List of Health Services, and the treatment is not included in guideline note 172 or 173 of the prioritized list, before the hearing the Division shall determine if the requested treatment is appropriate and necessary for the member.-¶
(b) For treatments determined to be appropriate and necessary under (a) in this section, the Division determines whether the HERC has considered the funded condition/treatment pair for inclusion on the Prioritized List within the last five years. If the HERC has not considered the pair for inclusion within the last five years, the Division shall make an ad hoc coverage determination in consultation with the HERC.¶
(c) For treatments determined to not be appropriate and necessary under (a) in this section the hearing process shall proceed.-¶
(14~~5~~5) General anesthesia for oral procedures. General anesthesia for oral procedures that are medically and orally necessary and appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-141-3835

RULE SUMMARY: Adds HRSN Services to MCE Service Authorization requirements

CHANGES TO RULE:

410-141-3835
MCE Service Authorization
(1) Coverage of services is outlined by MCE contract and OHP benefits coverage in OAR 410-120-1210 and 410-120-1160.¶
(2) A member may access urgent and emergency services 24 hours a day, seven 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, within the MCE's Provider Network without Prior Authorization of payment during the first thirty (30) days of treatment.¶
(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 based on medical necessity and medical appropriateness as defined in OAR 410-120-0000, or for HRSN Services that are appropriate and relevant to the HRSN Clinical Risk Factors and HRSN Social Risk Factors as described in 410-120-2000 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) 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, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:¶

(i) The member, the member's representative, or provider requests an extension; or¶
(ii) The MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.¶
(iii) For authorization requests relating to Climate Supports in an Area that is Experiencing Extreme Weather Events, as described in OAR 410-120-2000, MCE must provide authorization within 48 hours of receipt. ¶
(B) For notices of adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination takes effect:¶
(i) The MCE shall make an expedited authorization decision and 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 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.¶
(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)(A) 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~~s~~ shall consult with the requesting provider for medical, behavioral, or oral health services when necessary:¶
(~~i~~I) Requesting all the appropriate information to support decision making as early in the review process as possible; and¶
(~~ii~~II) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.¶
(~~B~~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~~I) Deny a service authorization request;¶
(~~ii~~II) Reduce a previously authorized service request; or¶
(~~iii~~III) Authorize a service in an amount, duration, or scope that is less than requested.¶
(B) For HRSN Services, the MCE shall adhere to OAR 410-120-2000.¶
(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 working 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 14 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 14-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.¶
(11) 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, ORS 414.610-414.685

AMEND: 410-141-3850

RULE SUMMARY: Adds HRSN Services to Transitions of Care requirements

CHANGES TO RULE:

410-141-3850
Transition of Care
(1) This rule applies to care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after disenrollment from a "predecessor plan," which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). This rule does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.¶
(2) For purposes of this rule, the following additional definitions apply:¶
(a) "Continued Access to Services" means making available to the member services, prescriptions, and prescription drug coverage consistent with the access they previously had including permitting the member to retain their current provider, even if that provider is not in the CCO network;¶
(b) "Medically Fragile Children (MFC)" as defined by OAR 411-300-0110 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);¶
(c) "Transition of Care Period" means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services. The transition of care period lasts for:¶
(A) Ninety (90) days for members who are dually eligible for Medicaid and Medicare; or¶
(B) For other members, the shorter of:¶
(i) Thirty (30) days for physical and oral health and sixty (60) days for behavioral health; or¶
(ii) Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan; or the minimum or authorized prescribed course of treatment has been completed.¶
(3) CCOs shall implement and maintain a transition of care policy that, at a minimum, meets the requirements defined in this rule and 42 CFR § 438.62(b). A receiving CCO must provide continued access to services to, at minimum, the following members:¶
(a) Medically Fragile Children (MFC);¶
(b) Breast and Cervical Cancer Treatment program members;¶
(c) Members receiving CareAssist assistance due to HIV/AIDS;¶
(d) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services (including pre-transplant and post-transplant services), radiation, or chemotherapy services; and¶
(e) Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.¶
(4) During the Transition of Care Period the receiving CCO shall ensure that any member identified in section (3) of this rule:¶
(a) Is provided with Continued Access to Services and has support necessary to access those services such as Non-Emergency Medical Transportation (NEMT);¶
(b) Is permitted to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's network;¶
(c) Is referred to appropriate providers of services that are in the network at the duration of the Transition of Care period;¶
(d) Notwithstanding section (4)(b) of this rule, the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:¶
(A) Prenatal and postpartum care;¶
(B) Transplant services through the first-year post-transplant;¶
(C) Radiation or chemotherapy services for the current course of treatment; ~~or~~¶
(D) Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.; or¶
(E) HRSN Services through the authorized timeframe of service provision for each such service as set forth in a Member's PCSP, as described in OAR 410-120-2000. ¶
(e) Where section (4) of this rule allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less than Medicaid fee-for-service rates;¶
(f) The receiving CCO is not financially responsible for a continuous inpatient hospitalization for which a

predecessor CCO was responsible under its contract, in accordance with OARs 410-141-3500, 410-141-3710, and 410-141-3805.¶
(5) After the Transition of Care Period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.¶
(6) The Predecessor Plan shall fully and timely comply with request for historical utilization data and clinical records within seven calendar days of the request from the receiving CCO.¶
(a) CCOs shall not delay the provision of services if historical utilization data and clinical records is not available in a timely manner;¶
(b) In such instances, the CCO is required to approve claims for which it has received no historical utilization data and clinical records during the transition of care time period, as if the covered services were prior authorized.
CCOs shall have 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. Such information must be incorporated into the CCO's records about the current member. With the approval and at the direction of a current or former enrollee or the enrollee's personal representative, the CCO must:¶
(A) Receive all such data for a current member from any other payer that has provided coverage to the enrollee within the preceding 5 years;¶
(B) At any time the member is currently enrolled in CCO 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 under this paragraph in the electronic form and format it was received.¶
(7) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835, and for HRSN Services all service authorization protocols outlined in OAR 410-120-2000, and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR 438.404 and OAR 410-141-3885, and to the extent applicable, OAR 410-120-2000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065