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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
10/31/2023 2:20 PM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Minor housekeeping edits to Oregon Health Plan Managed Care rules

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.

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NEED FOR THE RULE(S)

Minor housekeeping edits are needed to align with Federal requirements, clarify language, remove outdated references, and correct typos.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

None

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

Implementing the aforementioned rule changes will clarify operational requirements for managed care entities that serve Oregon Health Plan members and are tasked with prioritizing health equity for Oregonians.

FISCAL AND ECONOMIC IMPACT:

The Department/Authority does not anticipate there will be a fiscal impact from these rule changes.

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) The Department/Authority does not anticipate there will be a fiscal impact from these rule changes.
(2)
(a) None

(b) None

(c) None

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

None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-141-3525, 410-141-3530, 410-141-3585, 410-141-3875, 410-141-3885, 410-141-3890, 410-141-3900, 410-141-3910

AMEND: 410-141-3525

RULE SUMMARY: Strike OAR 410-141-0160 from the rule 410-141-3525

CHANGES TO RULE:

410-141-3525
Outcome and Quality Measures
~~Outcome and Quality Measures¶~~
~~(1)~~ (1) Managed Care Entities (MCEs) shall report to the ~~Authority~~Oregon Health Authority (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, 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 ~~q~~Quality ~~a~~Assessment and ~~p~~Performance ~~i~~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 (OAR), 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 O~~YA~~regon Youth Authority (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~~3860, 410-141-3865, 410-141-38~~6~~70; 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 ~~wi~~shall be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health). Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) Electronic Clinical Quality Measures (eCQM) and Healthcare Effectiveness Data and Information Set (HEDIS) that have state or national normative statistics;¶
(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational measures may include culturally informed care, health equity or health-related services not typically associated with medical care. Transformational metrics ~~wi~~shall also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.¶
(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.372 and 442.373 and the MCE agreement in the manner authorized by OAR 409-025-0130.¶
(10) The positions of Medical or Dental Director and the Q~~l~~uality Improvement (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 410-141-3860, 410-141-3865 and 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 (2) 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 Q~~l~~uality Improvement (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~~are to include an assessment of annual activities conducted which includes background and rationale, a plan of ongoing improvement activities to address gaps which ~~wi~~shall ensure quality of care for MCE members and overall effectiveness of the QI program. MCEs shall submit their evaluations to the Authority contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy as outlined in the MCE contract for the QAPI and transformational care annual evaluation criteria;¶
(d) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant member complaints and appeals as required in OAR 410-141-3915;¶
(e) Review written procedures, protocols, and criteria for member care no less than every two (2) years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3530

RULE SUMMARY: Add CAP requirement for sanctions as specified in contract.

CHANGES TO RULE:

410-141-3530
Sanctions
(1) The ~~Authority~~Oregon Health Authority (Authority) may establish and impose sanctions on M~~CEs~~anaged Care Entities (MCEs), pursuant to 42 CFR 438.700, if the Authority makes a determination specified in ~~paragraph~~section (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~~may 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;¶
(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 ~~s~~State or ~~f~~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 requirement~~s;¶~~
(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~~e) Additional sanctions available under Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR) that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance, which may include, without limitation¶
(i) Assessment of a recovery amount equal to one percent of Contractor's last total monthly Capitation Payment immediately prior to imposition of the Sanction. Such amount shall be set-off from Contractor's next total monthly Capitation Payment;¶
(ii) Require Contractor to develop and implement a Corrective Action Plan (CAP) that is acceptable to the Authority for correcting the problem; or¶
(iii) Where financial solvency is involved, actions may include increased reinsurance requirements, increased reserve requirements, market conduct constraints, or financial examinations.¶
(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~~mediation when requested:¶
(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: 410-141-3585

RULE SUMMARY: Add the term "subcontractors" to this rule to ensure timely notice is sent to member when a subcontractor is terminated.

REAL-D/SOGI demographic information and information about the provider's 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;

Addition of availability of no-cost help, Taglines shall be included within the body of the notice or other material; to avoid some confusion about tagline content and tagline placement.

CHANGES TO RULE:

410-141-3585
MCE Member Relations: Education and Information
(1) Managed Care Entities (MCEs) may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the ~~Authority~~Oregon Health Authority (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~~must 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 C~~care ~~C~~coordination ~~(ICC) S~~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~~ 950-060-0010 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~~, and oral interpretation to understand the information provided, ~~as well as~~ the availability of no cost help, alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit. Taglines shall be included within the body of the notice or document;¶
(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 ~~wi~~shall accept new members;¶
(g) Whether the provider offers both telehealth and in-person appointments;¶
(h) ~~I~~Race, Ethnicity, Language and Disability (REAL-D)/ Sexual, Orientation or Gender Identity (SOGI) demographic information and 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.¶
(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 fourteen (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 twelve (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 (5) 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 ICCcare coordination services and how eligible members may access those services. MCEs shouldmust ensure that ICCcare coordination 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 or subcontractors. The MCE shall provide, translated as appropriate, the notice at least thirty (30) days before the effective date of that change, or within fifteen (15) calendar days after receipt or issuance of the termination notice if the participating provider or subcontractor has not given the MCE sufficient notification to meet the thirty (30-)day notice requirement. The Authority shall review and approve the materials within two (2) 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: 410-141-3875

RULE SUMMARY: • Remove duplicative language requirements from G&A Eval Criterial elements #9 and #10

• Remove 42 CFR §§ 438.408(b)(1) and (2) and these rule from bullet (4) and (6).

• Remove (MSC 443) Hearing Request form and Notice of Hearing rights (OHP 3030)

CHANGES TO RULE:

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

~~obtain documentation of the facts concerning the appeal upon receipt;~~¶
(~~B~~A) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;¶
(~~C~~B) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;¶
(~~D~~C) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and¶
(~~E~~D) Ensure documentation of appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3915 and is consistent with contractual requirements.¶
(3) The MCE shall provide information to members regarding the following:¶
(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;¶
(b) Member rights and responsibilities; and¶
(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.¶
(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR ⍰⍰ 438.408~~(b)(1) and~~ (~~2~~a) and these rules.¶
(5) Upon receipt of a grievance or appeal, the MCE shall:¶
(a) Within (5) five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;¶
(b) Give the grievance or appeal to staff with the authority to act upon the matter;¶
(c) ~~O~~Consistent with confidentiality requirements, obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;¶
(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:¶
(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;¶
(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:¶
(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;¶
(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.¶
(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;¶
(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.¶
(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.¶
(7) MCEs shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501 and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.¶
(8) The following pertains to the release of a member's information:¶
(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:¶
(A) Resolving the matter; or¶
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.¶
(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.¶
(9) The MCE shall provide ~~m~~Members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:¶
(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;¶
(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR

438.10;¶
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and¶
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.¶
(10) The MCE, its subcontractors, and its participating providers may not:¶
(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;¶
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or¶
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.¶
(11) In all MCE administrative offices and in those physical, behavioral, and dental health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:¶
(a) OHP Complaint Form (OHP 3001);¶
(b) MCE appeal forms (OHP 3302; or approved facsimile);¶
(c) Hearing request form Request to Review a Health Care Decision (OHP 3302) ~~or (MSC 443) and Notice of Hearing Rights (OHP 3030)~~.¶
(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.¶
(13~~) If at t~~ The member~~'s~~ may request ~~the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hear~~continuation of benefits from their MCE for services that were discontinued. If the member qualifies for continuation of benefits the MCE must provide the services while the appeal or administrative hearing is pending pursuant to OAR 410-141-3910.¶
(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If the MCE delegates any other portion of the grievance and appeal process to a subcontractor, the MCE must, in addition to the general obligations established under OAR 410-141-3505, do the following:¶
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;¶
(b) Monitor the subcontractor's performance on an ongoing basis;¶
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and¶
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3885

RULE SUMMARY: 410-141-3885 (4): Add a member may select a different primary care provider at any time and align to SB 1529 section 10 (3) which states a CCO must assign a me a member of the CCO to a primary care provider if the member has not selected a primary care provider by the 90th day after enrollment in medical assistance.

• OAR 410-141-3885(2) (M-O): Add "member's authorized representative" to the applicable OAR and Contract Citations

• Diagnosis and Procedure codes submitted on the PA or with the claim must always be included in the NOABD including a description in plain language.

CHANGES TO RULE:

410-141-3885
Grievances & Appeals: Notice of Action/Adverse Benefit Determination
(1) When ~~a~~n Managed Care Entity (MCE) has made an adverse benefit determination, the MCE shall give the requesting provider, the ~~m~~Member and the member's representative a written ~~n~~Notice of ~~a~~Adverse ~~b~~Benefit ~~d~~Determination (NOABD). The notice shall:¶
(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;¶
(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule.¶
(2) The following are notice requirements for pre-service denials:¶
(a) Meet the content notice requirements specified in 42 CFR 438.404 and in the MCE contract, including the following information:¶
(A) MCE contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages;¶
(B) Date of the notice;¶
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or ~~b~~Behavioral ~~h~~Health (BH) professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last ~~30~~ninety (90) days, the NOABD sh~~ould~~all state PCP, PCD, BH provider assignment has not occurred;¶
(D) Member's name, date of birth, address, and OHP member ID number;¶
(E) Service requested and the adverse benefit determination the MCE intends to make, including whether the MCE is denying, (in whole or part) terminating, suspending, or reducing a service;¶
(F) Date service was requested by the provider or member;¶
(G) Name of the provider who requested the service;¶
(H) Effective date of the adverse benefit determination if different from the date of the notice;¶
(I) Diagnosis and procedure codes submitted with the authorization request including a description of all codes in plain language ~~if the MCE is denying a requested service because of line placement on the Prioritized List of Health Services or the diagnosis and~~. For services that do not include a procedure code ~~do not pair~~a description o~~n~~f the ~~Prioritized List~~requested service;¶
(J) Whether the MCE considered other conditions such as co-morbidity factors if the ~~service~~condition was below the funding line on the Prioritized List of Health Services ~~and other services~~ pursuant to OAR 410-141-3820 and 410-141-3830;¶
(K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;¶
(L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD ~~notice~~;¶
(M) The ~~member's~~Member, member representative or, ~~if~~ the ~~member provides their~~provider with the member's written consent as required under OAR 410-141-3890(1), ~~the provider's right to~~may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within sixty (60) days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right;¶

(N) The ~~member's or the provider's~~Member, member representative or the provider with the member's written consent has the right to request a contested case hearing ~~with the Authority only after~~either orally or in writing with the Authority 120 days from the date of the MCE's ~~Appeal~~ Notice of Appeal Resolution or where the MCE failed to meet appeal timelines ~~in OAR 410-141-3890 and~~(standard appeal sixteen (16) days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3890, expedited appeal 72 hours to review and resolve appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3895), and the procedures to exercise that right;¶
(O) The circumstances under which an appeal process or contested case hearing can be expedited and how the ~~member~~Member, member representative or the member's provider may request it. If the MCE denies a request for an expedited appeal, it shall be transferred to the standard appeal resolution timeframes;¶
(P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, ~~how to request that benefits be continued~~that continued benefits can be requested by the Member, member's representative or the provider with the member's written consent orally or in writing, the timeframes to request that benefits be continued as described in OAR 410-141-3910 and the circumstances under which the member may be required to pay the cost of these services; ~~and~~¶
(Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination~~.~~;¶
(R) Information on requesting help and who to contact; ¶
(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines; and¶
(T) Inclusion of the names of providers or clinics copied on the notice;¶
(b) Use an Authority approved NOABD notice form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD.¶
(3) The following are notice requirements for ~~P~~post~~-~~service denials:¶
(a) Meet the content notice requirements specified in 42 CFR 438.404 and in the MCE contract, including the following information:¶
(A) MCE contact information including name, address, and telephone number and subcontractor contact information, if applicable, included in the NOABD ~~notice~~ excluding any cover pages;¶
(B) Date of the notice;¶
(C) ~~MCE's name, address, and telephone number;¶~~
~~(D)~~ Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or ~~b~~Behavioral ~~h~~Health (BH) professional if the member has an assigned practitioner or the most specific information available if a member is not assigned to a practitioner due to the clinic/facility model. If the member has not been assigned a practitioner because they enrolled in the MCE within the last ~~30~~ninety (90) days, the NOABD sh~~ould~~all state PCP, PCD, BH provider assignment has not occurred;¶
(~~E~~D) Member's name, D.O.B, address, and OHP member ID number;¶
(~~F~~E) Service previously provided in plain language and the adverse benefit determination the MCE made;¶
(~~G~~F) Date the service was provided;¶
(~~H~~G) Name of the provider who provided the service;¶
(~~I~~H) Effective date (date claim denied) of the adverse benefit determination if different from the date of the notice;¶
(~~J~~I) Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language ~~if the MCE is denying the service because of line placement on the Prio~~. For services that do not include a procedure code a descr~~iptized List of Health Services or the diagnosis and procedure code do not~~on of the service provided in pl~~air on the Prioritized List~~n language;¶
(~~K~~J) Whether the MCE considered other conditions such as co-morbidity factors if the ~~service~~condition was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830. NOABD shall clearly indicate whether a medical review was performed and if not that the provider can resubmit claim with chart notes for review of comorbidity;¶
(~~L~~K) Clear and thorough explanation of the specific reasons for the adverse benefit determination. If the service has been denied as the provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the MCE have been made to obtain the documentation from the provider;¶
(~~M~~L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶
(~~N~~M) The ~~member's~~Member, member representative or, ~~if~~ the ~~member provides their~~provider with the member's

written consent as required under OAR 410-141-3890~~, the provider's right to~~(1), may file a written or oral appeal of the MCE's adverse benefit determination with the MCE within 60 days from the date of the NOABD, including information on exhausting the MCE's one level of appeal, and the procedures to exercise that right; ¶
(~~O~~N) The ~~member's or the provider's~~Member, member representative or the provider with the member's written consent has the right to request a contested case hearing ~~with the Authority only after~~either orally or in writing with the Authority 120 days from the date of the MCE's ~~Appeal~~ Notice of Appeal Resolution or where the MCE failed to meet appeal timelines ~~in OAR 410-141-3890 and~~(standard appeal 16 days to review and resolve appeal from date of receipt with a possible fourteen (14) day extension 410-141-3890, expedited appeal seventy two (72) hours to review and resolve appeal from date of receipt with a possible 14 day extension 410-141-3895~~;~~) and the procedures to exercise that right;¶
(~~P~~O) An explanation to the member that there are circumstances under which an appeal process or contested case hearing can be expedited and how the ~~member~~Member, member representative or the member's provider may request it, but that an expedited appeal and hearing ~~wi~~shall not be granted for post-service denials as the service has already been provided;¶
(~~Q~~P) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, ~~how~~that continued benefits can be requested by the member, member's representative or the provider with the member's written consent orally or in writing, the timeframes to request that benefits be continued~~;~~ as described in OAR 410-141-3910 and the circumstances under which the member may be required to pay the cost of these services;¶
(~~R~~Q) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination; and¶
(~~S~~R) A statement that the provider cannot bill the member for a service rendered unless the member signed an OHP Agreement to Pay form (OHP 3165 or 3166);¶
(S) To support their appeal, the member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the appeal timelines;¶
(T) Information on requesting help and who to contact; and¶
(U) Inclusion of the names of providers or clinics copied on the notice.¶
(b) Use an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD.¶
(4) The MCE shall provide a copy of the fo~~rm,~~llowing when an NOABD is issued:¶
(a) Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile~~, when the MCE issues a NOABD~~;¶
(b) Non-Discrimination Policy.¶
(5) For requirements of NOABD that affect services previously authorized, the MCE shall mail the notice at least ten (10) days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.¶
(6) In 42 CFR □□ 431.213 and 431.214, exceptions related to advance notice include the following:¶
(a) The MCE may mail the notice no later than the date of adverse benefit determination if:¶
(A) The MCE has factual information confirming the death of the member;¶
(B) The MCE receives notice that the services requested by the member are no longer desired or the MCE is provided with information that requires termination or reduction in services:¶
(i) All notices sent to a member under this section shall be in writing, clearly indicate the member understands that the services previously requested ~~wi~~shall be terminated or reduced as a result of the notice and signed by the member;¶
(ii) All notices sent by the MCE under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.¶
(C) The MCE ~~can~~ may verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;¶
(D) The MCE is unaware of the member's location and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;¶
(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or¶
(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.¶
(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE has:¶
(A) Facts indicating that an adverse benefit determination ~~should~~may be taken because of probable fraud on part of the member; and¶

(B) Verified those facts, whenever possible, through secondary resources.¶
(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.¶
(7) Within sixty (60) days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3890

RULE SUMMARY: • Remove CFR section and subsection as OAR timeframes are more stringent.

• Add language that if the MCE or Administrative Law Judge reverses a decision to deny a service that the MCE must notify the member/member rep. and member provider of the available service and how to access it within 72 hours from the date the reversal occurs.

CHANGES TO RULE:

410-141-3890
Grievances & Appeals: Appeal Process
(1) A member, member representative, ~~or a subcontractor~~ or provider with the member's written consent, may file an oral or written appeal with the Managed Care Entity (MCE) to:¶
(a) Express disagreement with an adverse benefit determination; or¶
(b) Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative. If the member leaves a voice mail message with the MCE indicating that they wish to appeal a denial the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt to reach the member (date(s) and time(s)) by phone and make note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.¶
(2) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.¶
(3) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:¶
(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;¶
(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:¶
(A) The member requests the extension; or¶
(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.¶
(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:¶
(A) Make reasonable efforts (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;¶
(B) Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision;¶
(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.¶
(4) For expedited resolution of an appeal please see OAR 410-141-3895. A request for an expedited appeal for a service that has already been provided to the member (post-service) ~~wi~~shall not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above section (3) of this rule.¶
(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.¶
(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR 438.408~~(b)(1) and~~ (~~2~~a) regarding the standard resolution of appeals by the MCE:¶
(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date;¶
(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.¶
(7) Parties to the appeal include, as applicable:¶
(a) The member and their representative; or¶
(b) The legal representative of a deceased Member's estate.¶
(8) The MCE shall resolve each standard appeal in time period defined above in section (4) of this rule. The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.¶
(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MCE must take the following steps:¶
(a) notify the Member, the member's representative (if applicable) both orally and in writing and the member's

provider in writing of the available services and how to access them;¶
(b) Enter the prior authorization into the system or adjust the encounter data claim representing the service.¶
(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.¶
(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of adverse benefit determination, as specified in OAR 410-141-3885, in addition to:¶
(a) The date the member filed the appeal with the MCE;¶
(b) The results of the resolution process and the date the MCE completed the resolution; ¶
(c) Effective date of the appeal decision; and¶
(~~b~~d) For appeals not resolved wholly in favor of the member:¶
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;¶
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;¶
(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and¶
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;¶
(E) Copies of the appropriate forms: Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.¶
(e) For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3900

RULE SUMMARY: Add clarity around if the Judge reverses a decision made by the MCE when those services must be provided.

CHANGES TO RULE:

410-141-3900
Grievances & Appeals: Contested Case Hearings
(1) A~~n~~ Managed Care Entity (MCE) shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing:¶
(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures;¶
(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;¶
(c) Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.¶
(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3) of this rule, below:¶
(a) The member shall file a hearing request with the Authority using form OHP 3302 or any other ~~Authority~~Oregon Health Authority (Authority)-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;¶
(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two (2) business days of the Authority's request;¶
(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:¶
(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;¶
(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.¶
(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:¶
(A) Date-stamp the hearing request with the date of receipt; and¶
(B) Submit the following required documentation to the Authority within two business days:¶
(i) A copy of the hearing request notice of adverse benefit determination, and notice of appeal resolution;¶
(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.¶
(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.¶
(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.¶
(5) The parties to a contested case hearing include, as applicable:¶
(a) The member and their representative; or¶
(b) The legal representative of a deceased Member's estate; and¶
(c) The MCE.¶
(6) The Authority shall refer the hearing request along with the notice of adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.¶

(7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within ninety (90) days from the date the MCE receives the member's request for appeal. The ninety (90-)day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request.¶
(8) For reversed ~~appeal and~~ hearing resolution services:¶
(a) For services not furnished while the appeal or hearing is pending. If the ~~MCE or the~~ Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination~~;~~. The MCE must take the following steps:¶
(A) notify the Member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;¶
(B) Enter the prior authorization into the system or adjust the encounter data claim representing the service.¶
(b) For services furnished while the appeal or hearing is pending. If the ~~MCE or the~~ Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the ~~s~~State shall pay for those services in accordance with the Authority policy and regulations.¶
(c) Any party to the hearing can file written exceptions or present argument to the Proposed and Final Order within ten working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of the MCE receiving the Final Order.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3910

RULE SUMMARY: • Add different ways that a member can request continuation of benefits by phone, letter, fax or by using the Review a Health Care Decision form.

• Change MCE sends the notice to “date of notice” within 10 calendar days after the MCE sends the notice of appeal resolution.

CHANGES TO RULE:

410-141-3910
Grievances & Appeals: Continuation of Benefits
(1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:¶
(a) ~~To be entitled to continuing benefits, the member shall complete an MCE appeal request or an Authority contested case hearing request~~A member can request continuation of benefits by phone, letter, fax or by using the Review of Health Care Decision form and check the box requesting continuing benefits by:¶
(A) The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or¶
(B) The effective date of the action proposed in the notice, if applicable.¶
(b) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;¶
(c) The Managed Care Entity (MCE) must continue the member's benefits if all of the following occur:¶
(A) The appeal involves the termination, suspension, or reduction of previously authorized services;¶
(B) The services were ordered by an authorized provider;¶
(C) The period covered by the original authorization has not expired; and¶
(D) The member timely files for continuation of benefits.¶
(d) If, at the member's request, the MCE continues or reinstates benefits while the appeal or hearing is pending, the benefits must be continued until one of the following occurs:¶
(A) The member fails to request a hearing and continuation of benefits within 10 calendar days after the ~~MCE sends~~date of the notice of appeal resolution;¶
(B) The member withdraws the appeal or request for hearing;¶
(C) A final order resolves the hearing.¶
(e) Member responsibility for services furnished while the appeal or hearing is pending. If the final resolution of the appeal or hearing is adverse to the member, that is, upholds the MCE's adverse benefit determination, the MCE may recover the cost of services furnished to the member while the appeal and hearing was pending, to the extent that they were furnished solely because of the requirements of this section.¶
(2) For reversed appeal and hearing resolution services:¶
(a) Benefits not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal/hearing was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination~~;~~. The MCE must take the following steps:¶
(A) notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;¶
(B) Enter the prior authorization into the system or adjust the encounter data claim representing the service.¶
(b) Benefits furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the Authority shall pay for those services in accordance with the Authority policy and regulations.
Statutory/Other Authority: ORS 413.032, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685