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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
10/06/2023 2:23 PM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Update time and distance standards. Clarify network monitoring expectations. Update and align healthcare interpreter requirements.

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)

Code of Federal Regulations (CFR) §438.60 requires that states develop and enforce network adequacy standards, including quantitative standards. OHA has set both time and distance and time to appointment standards in OAR 410-141-3515. These standards apply to the Coordinated Care Organizations (CCO) that manage the OHP benefit for the majority of OHP recipients around the state. The current quantitative standards are inadequate from a compliance perspective to ensure that the majority of CCO-enrolled OHP members do not have to travel excessive distances to access care, particularly for provider types that are most frequently accessed by OHP members such as primary care providers, dentists, and behavioral health providers. Current standards also inadequately address the CFR requirement to set quantitative standards around obstetric and gynecological care services. The proposed changes fully address CFR requirements and set clearer expectations for compliance that can be more effectively measured and monitored.

The proposed changes also align the 410-141-3515 language with the requirements regarding use of certified and qualified healthcare interpreters set forth in House Bill 2359 and in Chapter 950, Division 50 of Oregon Administrative Rule.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

https://www.oregon.gov/oha/HSD/OHP/Pages/network.aspx - This website contains methodology documentation, including documentation from a CCO around how they will use existing monitoring software to implement the proposed changes. The website also contains survey responses that guided the development and refinement of the proposed changes.

Chapter 950, Division 50 -https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7797

(Mavel Morales and Edna Nyamu)

House Bill 2359 - https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2359

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

The rule amendments have the potential to increase access to healthcare providers and services, as well as increase the utilization of high quality healthcare interpretation services, which may have a positive impact on health outcomes.

FISCAL AND ECONOMIC IMPACT:

Oregon Health Authority initially did not anticipate any fiscal impact as a result of these rule changes and provided the following fiscal impact statement for input during the RAC (held on 9/7/2023, "OHA does not anticipate there will be a fiscal impact from these rule changes."

During the Rules Advisory Committee meeting held on 9/7/2023, RAC members provided the following input on the proposed fiscal impact statement:

- Additional costs include the increased credentialing and recredentialing work, the exceptions process adds administrative burden reducing overall efficiency and there is a cost there. It also adds significant costs for the cadence and need for additional analysis and software purchases or software adaptations. Can we easily estimate the cost no, but it will be expensive. Concerns around the timeline to implement these changes. There will also be additional expenses related to the contracting process/staffing as well as legal expenses for contract reviews (clarified that this is related to the expansion of the provider networks).
- There are also costs for training the provider workforce.
- For dental, additional costs will include recruiting new PCDs. In some regions, there are no PCDs available, and for those PCDs that do exist, many are not interested in Medicaid. Therefore, it may be up to (former) DCOs to establish bricks and mortar solutions to achieve compliance, which would have a pronounced financial impact.

Given this feedback, OHA has revised its fiscal impact statement: Coordinated Care Organizations (CCO) may experience a fiscal impact as an indirect result of these proposed rule changes. Specific estimates of the fiscal impacts cannot be determined and may be associated with the costs of monitoring provider networks and recruiting additional providers based on the composition of the various CCO provider networks and the ability of those networks to ensure access to all covered services. Coordinated Care Organizations are currently obligated via Contract and State and Federal regulations to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees. The proposed changes to the time and distance standards in OAR are reflective of many (not all) of the providers necessary to render services covered under the OHP benefit, therefore costs associated with this rule change would also be associated with the existing obligation to maintain and monitor a provider network that is sufficient to provide adequate access to all covered 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. CCOs are currently required to maintain and monitor a network of appropriate providers sufficient to provide adequate access to all services covered under the OHP benefit. CCOs may need to dedicated resources to the recruitment and monitoring of providers necessary to ensure adequate access to covered services.

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

AMEND: 410-141-3515

RULE SUMMARY: Code of Federal Regulations (CFR) §438.60 requires that states develop and enforce network adequacy standards, including quantitative standards. OHA has set both time and distance and time to appointment standards in OAR 410-141-3515. These standards apply to the Coordinated Care Organizations (CCO) that manage the OHP benefit for the majority of OHP recipients around the state. The current quantitative standards are inadequate from a compliance perspective to ensure that the majority of CCO-enrolled OHP members do not have to travel excessive distances to access care, particularly for provider types that are most frequently accessed by OHP members such as primary care providers, dentists, and behavioral health providers. Current standards also inadequately address the CFR requirement to set quantitative standards around obstetric and gynecological care services. The proposed changes fully address CFR requirements and set clearer expectations for compliance that can be more effectively measured and monitored.

The proposed changes also align the 410-141-3515 language with the requirements regarding use of certified and qualified healthcare interpreters set forth in House Bill 2359 and in Chapter 950, Division 50 of Oregon Administrative Rule.

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 ~~wi~~shall 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 requirement~~In assessing the capacity and adequacy of its provider network, MCEs shall consider, in conjunction with the quantitative standards set forth in this rule, the variety of provider and facility types with the demonstrated ability and expertise to render specific medically or dentally appropriate covered services within the scope of applicable licensing and credentialling. This includes, but is not limited to, the prescribing of

Medication-Assisted Treatment and more specialized oral health care services.¶
(a)8) All MCEs shall ensure all95% of members can access the following provider and facility types, further defined by the Authority in guidance made available on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx, within acceptable travel time or distance standards set forth this rule:¶
(Aa) Mental healthTier one:¶
(A) Primary care providers serving adults, and those serving pediatrics, and;¶
(B) Primary care dentists serving both adults and those serving pediatrics;¶
(BC) DMental serviceshealth providers serving adults, and those serving pediatrics, and;¶
(D) Substance use disorder providers serving both adults and pediatricsthose serving pediatrics¶
(E) Pharmacy;¶
(CF) Specialty providers serving adults, serving pediatrics, and serving both adults and pediatrics;Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(Db) Substance use disorderTier two:¶
(A) Obstetric and gynecological service providers;¶
(B) The following specialty providers, serving adults, and those serving pediatrics, and serving both adults and pediatrics;¶
(i) Cardiology;¶
(ii) Neurology;¶
(iii) Occupational Therapy;¶
(iv) Medical Oncology;¶
(v) Radiation Oncology;¶
(vi) Ophthalmology;¶
(vii) Optometry;¶
(viii) Physical Therapy;¶
(ix) Podiatry;¶
(x) Psychiatry;¶
(xi) Speech Language Pathology.¶
(C) Hospital;¶
(ED) Primary care providers serving adults, servDurable medical equipment;¶
(E) Methadone Clinic;¶
(F) Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(c) Tier three:¶
(A) The following spedciatrics, andlty providers, serving both adults and those serving pediatrics;;¶
(Fi) Patient Centered Primary Care Homes;¶
(G) Federally Qualified Health CentersAllergy & Immunology;¶
(ii) Dermatology;¶
(iii) Endocrinology;¶
(iv) Gastroenterology;¶
(Hv) Hospital;¶
(I) Hospital, acute psychiatric care;¶
(J) Rural Health Centersematology;¶
(vi) Nephrology;¶
(vii) Otolaryngology;¶
(viii) Pulmonology;¶
(K) Pharmacies;¶
(Lix) Rheumatology;¶
(x) Urology.¶
(B) Post-hospital skilled nursing facilities;¶
(M) Urgent Care Centers;¶
(NC) Additional provider types when it promotes the objectives of the Authority or as required by legislation.¶
(b9) 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 minutesthe Authority shall provide tools and additional guidance specific to time and distance monitoring on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶

(a) A CCO service area may contain multiple geographic designations. When calculating travel time and distance, geographic designations shall not overlap and the following definitions of geographic designations shall apply:¶
(A) Large urban area: Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.¶
(B) Urban area: An area with greater than 40,000 people within a 10 mile radius of a city center.¶
(C) Rural area: An area greater than 10 miles from the center of an urban area.¶
(D) County with extreme access considerations: County with a population density of 10 or fewer people per square mile.¶
(b) When calculating travel time and distance, MCEs shall use the following standards: ¶
(A) Large Urban Area:¶
(i) Tier one: 10 minutes or 5 miles¶
(ii) Tier two: 20 minutes or 10 miles¶
(iii) Tier three: 30 minutes or 15 miles ¶
(B) Urban Area: ¶
(i) Tier one: 25 minutes or 15 miles¶
(ii) Tier two: 30 minutes or 20 miles¶
(iii) Tier three: 45 minutes or 30 miles¶
(C) Rural Area: ¶
(i) Tier one: 30 minutes or 20 miles¶
(ii) Tier two: 75 minutes or 60 miles¶
(iii) Tier three: 110 minutes or 90 miles¶
(D) County with Extreme Access Considerations: ¶
(i) Tier one: 40 minutes or 30 miles¶
(ii) Tier two: 95 minutes or 85 miles¶
(iii) Tier three: 140 minutes or 125 miles¶
(10) MCEs may request an exception to a standard set above. MCEs may request multiple exceptions.¶
(a) Exception requests must be submitted in a format provided by the Authority and made available on the CCO Contract Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶
(b) The Authority shall review and approve or deny exception requests based on criteria made available on the CCO Contracts Forms webpage. Approved exceptions must be reviewed at least annually.¶
(~~8~~11) 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 based on the expected utilization of services referenced above and the number and types of providers actively providing services within the MCE's current provider network;¶
(c) How the MCE ~~wi~~shall 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~~12) 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.¶
(1~~0~~3) 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.¶

(1~~1~~4) 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 (4) 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 (2) weeks;¶
(C) Routine oral care: Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) 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 (1) week;¶
(C) Routine oral care: Within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) 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 (5) 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 (7) days of the request, with a second appointment occurring as clinically appropriate.¶
(1~~2~~5) 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, as detailed in OAR Chapter 950, Division 050 for those who have Limited English Proficiency, ~~living in a household w~~prefer to communicate in a language oth~~ere th~~ere ~~is no adult available t~~an English or who communicates in ~~English or there is no telephone:~~signed language.¶
(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~~¶

(e) MCEs shall comply with requirements of the Americans with ~~a d~~Disabilit~~y, 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 Disabilitie~~ies Act of 1990, as amended via the ADA Amendments Act of ~~1990~~2008, 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.¶

(1~~3~~6) 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~~7~~) 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~~8~~) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).¶

(16~~9~~) 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, or lack of interpreter services, MCEs shall provide outreach services a~~s medically appropriate~~nd offer Care Coordination as medically appropriate to make a plan with the member to resolve barriers;¶

(d) Recognition of whether NEMT services were the cause of the member's missed appointment.¶

(~~17~~20) 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.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685