2022 Changes to OARs 410-141 Oregon Health Plan

Summary of all changes

410-141-3500 Definitions

- Add definition for "Plan Type" (Changes to language)

410-141-3515 Network Adequacy

- Correct reference to behavioral health rule (Changes to language)

410-141-3575 MCE Member Relations: Marketing

- Add definition for "Written Member Materials" (Changes to language)

410-141-3585 MCE Member Relations: Education and Information

- Remove individual criteria from rule and instead reference compliance with the Member Handbook Evaluation Criteria issued and updated by OHA every year. (Changes to language)
- Add language to clarify termination notice mailing timeline to align with 42 CFR 438.10 (f) (1). (Changes to language)

410-141-3845 Health-Related Services

- Remove outdated OAR reference. (Changes to language)

410-141-3890 Grievances & Appeals: Appeal Process

- Remove inaccurate reference to filing an appeal if a member wants to contest an MCE's failure to act within appeal timeframes. Member would ask for a hearing in this case, not an appeal. (Changes to language)
- Align appeal extension requirements with 42 CFR 438.408 (c) (2). (Changes to language)
- Align party requirements with 42 CFR 438.406 (b) (6). (Changes to language)
- Remove reference to hearing forms that are not specific to CCOs. (Changes to language)

410-141-3895 Grievances & Appeals: Expedited Appeal

- Align expedited appeal extension requirements with 42 CFR 438.408 (c) (2) (Changes to language)

410-141-3900 Grievances & Appeals: Contested Case Hearings

- Replace reference to general hearing form with CCO-specific hearing form. (Changes to language)
- Align party requirements with 42 CFR 438.408 (f) (3) (Changes to language)

410-141-3960 Transportation: Member Reimbursed Mileage, Meals, and Lodging

- Add language to clarify travel requirement. (Changes to language)

Specific changes to rule language

Changes to language in 410-141-3500

(##) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. A client whose oral health services are paid by the fee-for-service program may be enrolled in a dental care organization (DCO) directly contracted by OHA if the client's residence is covered by the DCO's service area. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:

(a) CCOA: Physical, oral, and behavioral health services are paid by the client's CCO.

(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Oral health services are paid by the fee-for-service program.

(c) CCOE: Behavioral health services are paid by the client's CCO. Physical and oral health services are paid by the fee-for-service program.

(d) CCOG: Oral and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.

Changes to language in 410-141-3515 (11) (d)

(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 below for assessment and entry, terms are defined in OAR 309-019-~~1015~~**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;

Changes to language in 410-141-3575 (1)

(1) The following definitions apply for purposes of OAR 410-141-3575 through 410-141-3585:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. This term includes, at a minimum, the types of alternate formats defined under the Americans with Disabilities Act (ADA) and 45 CFR Part 92, and shall include: braille, large (18 point) print, audio narration, oral presentation, electronic file, sign language interpretation, and sighted guide;

(b) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the MCE;

(c) "Marketing" means any communication from an MCE to a potential member who is not enrolled in the MCE that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE;

(d) "Marketing Materials" means materials that are produced in any medium by or on behalf of an MCE and that can reasonably be interpreted as intended to market to potential members;

(e) "Outreach" means any communication from an MCE to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the MCE's subcontractors and partners, and the MCE contractually required programs and services; and the promotion of healthful behaviors, health education and health related events. For full benefit dual eligible (FBDE) members, outreach to provide information about opportunity to align Medicare and Medicaid benefits, or CMS approved Default or Simplified enrollment for newly Medicare eligible member in the CCO regarding MA or DSNP, is allowable subject to OHA or CMS materials review.

(f) "Outreach Materials" means materials that are produced in any medium, by or on behalf of an MCE that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE;

(g) "Potential Member" means, as defined in OAR 410-141-3500, a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE;

(h) "Prevalent Non-English Language" means all non-English languages that are identified during the eligibility process as the preferred written language by the lesser of:

(A) Five percent of the MCE's total OHP enrollment; or

(B) One thousand of the MCE's members;

(i) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(j) "Written Member Materials" means informational and educational communications for members or potential members that are produced by or on behalf of an MCE in any written medium, including but not limited to: letters, brochures, guides, scripts, websites, email, text messaging.

All written member materials must comply with the Authority's formatting and readability standards, as described in OAR 410-141-3585 and 42 CFR § 438.10, and be written in plain language sufficiently clear that a layperson could understand the information."

Changes to language in 410-141-3585 (12) and (13)

(12) **MCE Member Handbooks must 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.**

~~The CCO member handbook shall be written in plain language using a font size no smaller than 12 point. At a minimum, the member handbook shall contain the following:~~

~~(a) Revision date including month, day, and year;~~

~~(b) Tag lines in English and other prevalent non-English languages, as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18 point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:~~

~~(A) How members may, at no cost to them, access sign language and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;~~

~~(B) The toll-free and TTY/TDY telephone numbers of the MCE's customer service unit.~~

~~(c) CCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;~~

~~(d) Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;~~

~~(e) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the CCO's policy on changing PCPs;~~

~~(f) Explanation of the health risk screening process;~~

~~(g) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;~~

~~(h) Explanation that American Indian and Alaskan Native members of the CCO may receive care from a tribal wellness center, Indian Health Services clinic, or the Native American Rehabilitation Association of the Northwest (NARA);~~

~~(i) Explanation of which participating or non-participating provider services the member may self-refer;~~

~~(j) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;~~

~~(k) Information on how to obtain a second opinion;~~

~~(L) Explanation of ICC services, including persons eligible as priority populations served and requirements for ICC care planning, and how eligible members may access those services;~~

~~(m) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;~~

~~(n) Explanation of care coordination services and how the member can request and access a care coordinator;~~

~~(o) Information about the benefits and availability of Traditional Health Worker (THW) services as defined in OAR 410-180-0305, and how to contact the CCO's THW liaison;~~

~~(p) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;~~

~~(q) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies and use of 911;~~

~~(r) Information on how to contact the CCO's in-house or subcontracted after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long term care provider or facility.~~

~~(s) Information on contracted hospitals in the member's service area including hospital name, physical address, toll-free phone number, TTY, and webpage;~~

~~(t) Information on mobile crisis services and crisis hotline for members, including information that crisis response services are available 24 hours a day for members receiving Intensive In-Home Behavioral Health Treatment;~~

~~(u) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;~~

~~(v) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (3) and (4) of OAR 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services;~~

~~(w) A statement or narrative that articulates the CCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;~~

~~(x) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;~~

~~(y) Information on the CCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:~~

~~(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3875;~~

~~(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;~~

~~(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.~~

~~(z) Information on the member's rights and responsibilities, including the rights of minors, and availability of the Authority Ombudsperson;~~

~~(aa) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;~~

~~(bb) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;~~

~~(cc) Information on coverage and billing for out of state services, including information how to access additional assistance from the CCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;~~

~~(dd) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including how to access such services and specific communications for members who are becoming new Medicare enrollees;~~

~~(ee) Information on advance directive policies including:~~

~~(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;~~

~~(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;~~

~~(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with the Authority, and information on how to file such a complaint with the Authority;~~

~~(ff) Whether or not the CCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;~~

~~(gg) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;~~

~~(hh) How and when members are to obtain ambulance services;~~

(ii) Resources for help with transportation to appointments with providers and scheduling process for use of Non-Emergency Medical Transportation (NEMT) services;

(jj) All NEMT policies and procedures as outlined in OAR 410-141-3920 through 410-141-3965 and the CCO Contract, unless the member is provided with a stand-alone document, referred to as a "NEMT Rider Guide";

(kk) Explanation of the covered and non-covered services in sufficient detail to ensure that members understand the benefits to which they are entitled, including but not limited to;

(A) A delineation of the non-covered services the CCO coordinates from the non-covered services the CCO does not coordinate;

(B) Contact information for the Authority contractor responsible for coordination of non-covered services the CCO is not obligated to coordinate;

(C) Explanation that the CCO is responsible to arrange transportation for non-covered services that are coordinated by the CCO.

(LL) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the CCO and how to contact the Authority for information regarding accessing the service;

(mm) How to access in-network retail and mail-order pharmacies;

(nn) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(oo) The CCO's confidentiality policy;

(pp) Explanation of the CCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly;

(qq) How and where members may access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(rr) When and how members may voluntarily and involuntarily disenroll from CCOs and change CCOs;

(ss) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including CCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the CCO's written transition of care policy;

(tt) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(uu) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(13) The DCO member handbook shall be written in plain language using a font size no smaller than 12 point. The DCO member handbook is required for DCOs directly contracted by the Authority. At a minimum, the member handbook shall contain the following:

(a) The revision date, including month, day, and year;

(b) Tag lines in English and other prevalent non-English languages, as defined in as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18-point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:

(A) How members may access free sign and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;

(B) The toll-free and TTY/TDY telephone numbers of the DCO's customer service unit.

(c) DCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;

(d) The toll-free number for any partners providing services directly to members, including non-emergency medical transportation providers;

(e) The DCO's confidentiality policy;

(f) Information about the structure and operations of the DCO, including whether or not the DCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;

(g) Explanation of oral health benefits and covered services available to members without charge in sufficient detail to ensure that members understand the benefits to which they are entitled;

(h) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including DCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the DCO's written transition of care policy;

(i) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a Primary Care Dentist (PCD), other prescribing provider, or obtain new orders during that period;

(j) Explanation of how to choose a PCD, how to make an appointment, how to change PCDs, and the DCO's policy on changing PCDs;

(k) Explanation that American Indian/Native Alaskan members may choose an Indian Health Care Provider (IHCP) as the member's PCD if:

(A) The IHCP is participating as a PCD within the provider network; and

(B) The member is otherwise eligible to receive services from such Indian Health Care Provider; and

(C) The IHCP has the capacity to provide the services to such members.

(L) Explanation that American Indian members may obtain covered services from non-participating providers and can be referred by an IHCP to a participating provider for covered services in accordance with 42 CFR §438.14;

(m) Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;

(n) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (3) and (4) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services;

(o) Explanation of the health risk screening process;

(p) Information about tobacco dependency and cessation services and how to access such services through the DCO;

(q) Explanation of non-emergency medical transportation (NEMT) services, including how the DCO coordinates NEMT services for members and how a member accesses NEMT services;

~~(r) Explanation of care coordination services and how the member can request and access a care coordinator, including information that the DCO must coordinate dental services furnished to the member with the services the member receives from other plans and/or from community and social support providers;~~

~~(s) Policies on referrals, prior authorization and pre-approval requirements and how to request a referral, including but not limited to the following:~~

~~(A) No prior authorization or referral is necessary for urgent or emergency dental services including dental post-stabilization services;~~

~~(B) Information on how to access specialty dental care furnished by the DCO;~~

~~(C) Information on how to access specialty care and other benefits that are not furnished by the DCO.~~

~~(t) Information on how to obtain a second opinion;~~

~~(u) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;~~

~~(v) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the DCO and how to contact the Authority for information regarding accessing the service;~~

~~(w) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;~~

~~(x) How and when members are to use emergency services, both locally and when away from home, including examples of dental emergencies and use of 911;~~

~~(y) Information on how to contact the DCO's after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long-term care provider or facility;~~

~~(z) Explanation that members can access dental services while out of state in an urgent or emergency situation, including information on how to access additional assistance from the DCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;~~

~~(aa) Information on when and how members may voluntarily and involuntarily disenroll from DCOs or change DCOs;~~

~~(bb) A statement or narrative that articulates the DCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;~~

~~(cc) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;~~

~~(dd) Information on the DCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:~~

~~(A) Information about assistance in filling out forms and completing the grievance process available from the DCO to the member as outlined in OAR 410-141-3875;~~

~~(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;~~

~~(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.~~

~~(ee) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;~~

~~(ff) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;~~

~~(gg) Explanation of the DCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly, including contact information for the DCO's Non-discrimination coordinator;~~

~~(hh) Information about the requirement to provide providers and subcontractors with third-party liability information;~~

~~(ii) Explanation that the DCO will provide written notice to affected members of any significant changes in provider, program, or service sites that affect the member's ability to access care or services from the DCO's participating providers. Such notice shall be translated as appropriate and provided to the member at least 30 days before the effective date of the change, or as soon as possible if the participating provider has not given the DCO sufficient notification to meet the 30-day notice requirement;~~

~~(jj) Information on advance directive policies including:~~

~~(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;~~

~~(B) The DCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;~~

~~(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with the Authority, and information on how to file such a complaint with the Authority;~~

~~(kk) DCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the DCO's internal changes. If changes affect the member's ability to use services or benefits, the DCO shall offer the updated member handbook to all members;~~

~~(LL) The "Oregon Health Plan Client Handbook" is in addition to the DCO's member handbook, and an DCO may not use it to substitute for any component of the DCO's member handbook.~~

Please note: After removing #13, we would need to renumber the rest of 410-141-3585

Changes to language in 410-141-3585 (14)

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) Information specifying that MCEs shall not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:

(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the member needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;

(d) An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) MCEs shall provide written notice to affected members of any Material Changes to Delivery System as defined in OAR 410-141-3500 or any other significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, **or 15 calendar days after receipt or issuance of the termination notice** ~~or as soon as possible~~ if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.

Changes to language in 410-141-3845 (5)

(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality. CCOs shall designate a role for the community advisory council in health-related services community benefit initiative spending decisions ~~as provided in OAR 410-141-3735~~.

Changes to language in 410-141-3890 (1) (b)

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 MCE to:

(a) Express disagreement with an adverse benefit determination; or

~~(b) Contest the MCE's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.~~

(c) 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.

Changes to language in 410-141-3890 (3) (c)

(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 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.

Changes to language in 410-141-3890 (7)

(7) Parties to the appeal include, as applicable:

(a) The ~~MCE and the~~ member **and their representative**; or

(b) The legal representative of a deceased Member's estate; and

(~~b~~**c**) The MCE and the member's provider.

Changes to language in 410-141-3890 (11)(b)(E)

(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 action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

(a) The results of the resolution process and the date the MCE completed the resolution; and

(b) 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:

~~(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or~~

(ii) Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.

Changes to language in 410-141-3895 (4)(e)(A)

(4) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;

(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request;

(c) Mail written confirmation of the resolution to the member within three days;

(d) Extend the timeframes 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.

(e) If the MCE extends the timeframes 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 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 he or she disagrees with that decision.

Changes to language in 410-141-3900 (2) (a)

(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), below:

(a) The member shall file a hearing request with the Authority using form ~~MSC 0443~~ **OHP 3302** or any other 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;

Changes to language in 410-141-3900 (5)

(5) The parties to a contested case hearing include ~~the following~~**, as applicable**:

(a) The ~~MCE and the~~ member **and their representative**; or

(b) The legal representative of a deceased Member's estate; and

(~~b~~**c**) The MCE and the member's provider.

Changes to language in 410-141-3960 (7)

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment; **or**

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.