**410-141-3515 Network Adequacy (Proposed Changes for 1/1/21)**

(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate will become enrolled as members.

(2) The MCE shall develop a provider network that enables members to access services within the standards defined below.

(3) The MCE shall meet access-to-care standards and 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) CCOs 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 CCO 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) CCOs shall ensure all members can access providers within acceptable travel time or distance to patient-centered primary care homes or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral care, adult and pediatric; and additional provider types when it promotes the objectives of the Authority. Acceptable travel times and distances may not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas, 30 miles, or 30 minutes;

(b) In rural areas, 60 miles, or 60 minutes.

(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan shall include how the CCO will meet the accommodation and language needs of individuals with LEP as defined in 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.

(9) CCOs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance

with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.

(10) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO 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. Specifically, 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 5 years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.

(11) CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:

(a) Physical health:

(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;

(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;

(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.

(b) Oral care:

(A) Emergency oral care: Seen or treated within 24 hours;

(B) Urgent oral care: Within one week or as indicated in the initial screening in accordance with OAR 410-123-1060;

(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

(c) Behavioral health:

(A) Urgent behavioral health care for all populations: ~~Immediately~~ 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, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;

(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;

(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;

(iv) Opioid use disorder: Assessment and entry within 72 hours;

(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;

(vi) Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.

(C) Routine behavioral health care for non-priority populations: assessment within seven days of the request, with a second appointment occurring as clinically appropriate.

(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who have limited English proficiency, living in a household where there is no adult available to communicate in English or there is no telephone:

(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives;

(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members;

(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;

(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCES shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;

(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;

(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;

(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:

(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;

(B) MCEs shall complete a quarterly language access and interpreter services data report using the report form provided by the Authority. The quarterly language access and interpreter services data report shall be submitted to the Authority on or before the third Monday of each January, April, July, and October. Reporting for Calendar Year 2020 shall commence in April 2020. January reporting requirements shall commence at the beginning of Calendar Year 2021;

(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.

(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. MCEs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.

(14) MCEs must report annually to the Authority such access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:

(a) Behavioral health access;

(b) Interpreter utilization by the MCE's provider network;

(c) Behavioral health provider network.

(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).

(16) MCEs shall implement and require its providers to adhere to the following appointment and wait time standards:

(a) Wait times for scheduled appointments shall not exceed 60 minutes. After 30 minutes, members must be given an update on waiting time with an option of waiting or rescheduling the appointment. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;

(b) MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:

(A) Timely rescheduling of missed appointments, as deemed medically appropriate;

(B) Documentation in the clinical record or non-clinical record of missed appointments;

(C) Recall or notification efforts; and

(D) Method of member follow up.

(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, MCEs shall provide outreach services as medically appropriate;

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

(17) CCOs must contract with the following specific provider types:

(a) Providers of residential chemical dependency treatment services;

(b) Any oral care organizations necessary to provide adequate access to oral services in the area where members reside.

(18) CCOs shall assess the needs of their membership and make available supported employment and assertive community treatment services when members are referred and eligible:

(a) CCOs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by OHA. 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 services available;

(b) If 10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive assertive community treatment for more than 30 days, CCOs 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 Assertive Community Treatment provider is available, the CCO 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

History:

DMAP 55-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3525 Outcome and Quality Measures (Proposed Changes for 1/1/21)**

(1) MCEs shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS.

(2) The MCE shall inform the Authority if it has been accredited by a private independent accrediting entity. If the MCE has been so accredited, the MCE shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review in accordance with CFR 42 CFR §438.332.

(3) As required by health system transformation, MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. Measures are selected by OHA; 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, oral health care, and all other health services provided by or under the responsibility of the MCE as specified in the MCE's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.

(5) MCEs shall implement an ongoing comprehensive quality assessment and performance improvement program (QAPI) for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the MCE's contract. This process shall include an internal Quality Improvement (QI) program with written criteria based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with the requirements set forth in 42 CFR §438.330, relevant law and the community standards for care, or in accordance with accepted medical practice, whichever is applicable, and with accepted professional standards. MCEs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with MCE contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3890 through 410-141-3915;

(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid

funded long-term care or long-term services and supports benefits; or who are children receiving CAF (Child Welfare) or OYA services; and

(e) Report on the diversity and capacity of the workforce in their service area including capacity to provide services in a culturally responsive and trauma informed manner, relying, as appropriate, 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, or oral health care; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3860; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.

(8) MCEs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts. Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) eCQMs or HEDIS that have state or national normative statistics;

(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational measures may include culturally informed care, health equity or health-related services not typically associated with medical care. Transformational metrics will also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.

(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the MCE agreement in the manner authorized by OAR 409-025-0130.

(10) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. MCEs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The QI Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Authority members including those who are eligible for intensive care coordination (ICC) services under OAR 410-141-3870 or shall be able to retain consultation from individuals who are qualified.

(11) MCEs shall establish a QI Committee that shall meet at least every two months. The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:

(a) D~~d~~evelop and operate an 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 OHA quality staff, upon request;

(~~b~~c) MCEs shall conduct and submit to the Authority an annual written evaluation of the QI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the QAPI program and member care is to include an assessment of annual activities conducted which includes background and rationale, a plan of ongoing improvement activities to address gaps which will ensure quality of care for MCE members and overall effectiveness of the QI program. MCEs shall submit their evaluations to the Authority contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy as outlined in the MCE contract for the QAPI and transformational care annual evaluation criteria.

(d~~c~~) 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~~d~~) Review written procedures, protocols and criteria for member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

History: DMAP 55-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3565 Managed Care Entity Billing (Proposed Changes for 1/1/21)**

(1) Providers shall submit all ~~billings~~ claims for MCE members in the following timeframes:

(a) Submit initial claims ~~submissionsb~~~~illings~~ within no more than 120 days~~four months~~ of the date of service for all cases, except as provided for in section (1)(b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

(b) Submit ~~billings~~ initial claims within 365 days ~~12 months~~ of the date of service in the following cases:

(A) Pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the MCE is responsible for the Medicare reimbursement;

(D) Other cases that delay the initial ~~billing~~ claim to the MCE, not including failure of the provider to verify the member's eligibility; or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL.

(c) For initial claims submitted timely that need correction, have prompted a provider appeal as outlined in OAR 141-120-1560, or for a reason not included in (1)(b) of this rule that otherwise require a re-submission, MCEs shall establish a time-frame in their policies and procedures which allow a billing provider to make such re-submissions or appeals for a minimum of 180 days after the initial adjudication date.

(2) Providers shall be enrolled with the Authority to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Authority before enrollment with the Authority or to be eligible for MCE payment for services. FFS providers may be retroactively enrolled in accordance with OAR 410-120-1260 Provider Enrollment.

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Authority programs and;

(b) Assigned to an MCE on the date of service.

(5) Providers shall use the Authority's and MCE's tools to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165 "OHP Client

Agreement to Pay for Health Services," or facsimile signed by the client as described in OAR 141-120-1280.

(6) If a member has other insurance coverage available for payment of covered services, the insurance must be exhausted prior to payment for the covered services. Member cost-sharing incurred as part of other coverage shall be paid to the insurer by the MCE.

(7) MCEs shall pay for all covered services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. No contracting provider or agent, trustee or assignee of the contracting provider shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule and under 410-120-1280:

(a) A client may not be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(8) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider:

(a) MCEs shall have written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify timeframes for:

(A) Date stamping claims when received;

(B) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pended claims to obtain additional information;

(D) Sending written notice of the decision with appeal rights to the member and the provider when the determination is a denial, ~~in whole or in part, of payment for a service~~ in whole or in part, of payment for a service rendered as outlined in~~;~~ OAR 410-141-387~~8~~5 and 410-141-3885.

(b) MCEs shall pay or deny at least 90 percent of valid claims within 30 days of receipt and at least 99 percent of valid claims within 90 days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt;

(c) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3885;

(d) MCEs may not require providers to delay ~~billing~~ claims submission to the MCE;

(e) MCEs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare;

(f) MCEs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(g) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(h) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis;

(i) MCEs may not deny a claim for behavioral health services on the basis that such services were delivered in the member's home unless the MCE would deny a claim for comparable physical health services performed at the same site of service.

(9) MCEs shall pay for Medicare coinsurances and deductibles consistent with Oregon's State Plan methodology up to the Medicare or MCE's allowable for all Medicare Part A and Part B covered services the member receives from a Medicare enrolled provider after adjudication with Medicare or a Medicare Advantage plan:

(a) Providers must be enrolled in Oregon Medicaid to receive cost-sharing payments and non-enrolled providers should be given information on how to enroll to receive cost-sharing. Pursuant to OAR 410-120-1280(i), FFS Medicare providers should be encouraged to submit the Medicaid information necessary to enable electronic crossover to the MCE with their Medicare claims;

(b) MCE and affiliated Medicare Advantage plan shall provide a process for automatic Medicare to Medicaid crossover payments to ensure cost-sharing and reduce duplicate provider submission of claims;

(c) Federal law bars Medicare providers and suppliers from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays;

(d) MCE must inform providers of rules that prohibit balance billing and ensure providers serving and accepting plan payment for Qualified Medicare Beneficiaries mean members cannot be balance-billed per Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act.

(10) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(11) MCEs shall pay for ancillary covered services provided by a non-participating provider under the following conditions:

(a) MCEs shall pay for ancillary covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

(A) It can be verified that a participating provider ordered or directed the covered services to be delivered by a non-participating provider;

(B) The ancillary covered service was delivered in good faith without the prior authorization;

(C) The ancillary covered service would have been prior authorized with a participating provider if the MCE's referral procedures had been followed.

(b) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with OAR 410-141-3565 (12-14);

(c) Except as specified in OAR 410-141-3840 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(d) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(e) MCEs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies including but not limited to pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements. MCE shall pay hospitals any applicable Qualified Directed Payments pursuant to OAR 410-125-0230.

(12) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (12) and (14) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

(b) The Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3555 and 410-141-3560;

(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(13) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" are not subject to determination via the algorithm and shall remain on CBR.

(14) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table on the Authority's website.

(15) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the MCE or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;

(e) The Authority may not pay a provider for providing services for which an MCE has received an MCE payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Authority or an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);

(g) MCE's that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the MCE would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of Section 4712(b)(2) of the Balanced Budget Act of 1997.

(16) MCEs shall maintain a Coordination of Benefits Agreement that allows participation in the automated claims crossover process with Medicare for those members dually eligible for Medicaid and Medicare services.

(17) MCEs shall ensure providers under the MCE contract are notified of billing processes for crossover claims processing, as described in OAR 410-120-1280.

(18) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-3825 Excluded Services and Limitations for OHP Clients.

(19) MCEs shall engage in collaborative efforts with the Authority to achieve the requirements of the CCO Value-based Purchasing Roadmap.

Statutory/Other Authority: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.065 & 414.610 - 414.685

History:

DMAP 55-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3570 Managed Care Entity Encounter Claims Data Reporting**
**(Proposed Changes for 1/1/21)**

(1) MCEs shall meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Authority's 837 technical specifications for encounter data, and the Authority's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site.

(2) MCEs shall collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the MCE must utilize the HIPAA standards:

(a) MCEs shall submit encounter claims for all covered services, except for health-related services, provided to members as defined in OAR 410-120-0000 and 410-141-3500;

(b) MCEs shall submit encounter claims data including encounters for:

(A) Services where the MCE determined that liability exists; even if the MCE did not make any payment for a claim;

(B) Services where the MCE determined that no liability exists;

(C) Services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program;

(D) Paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the MCE, or the MCE's subcontractor; and

(E) Services to members who also have Medicare coverage, if a claim has been submitted to the MCE.

(c) MCEs shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare pursuant to 42 CFR 438.3(t);

(d) MCEs shall report encounter claims data whether the provider is an in-network participating or out-of-network, non-participating provider.

(3) MCEs shall follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

(4) MCEs shall submit all valid unduplicated encounter claims: professional, dental, institutional, and pharmacy within 45 days of the date of adjudication:

(a) MCEs shall ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their web site or by contacting the National Council for Prescription Drug Programs organization;

(b) Submission Standards and Data Availability:

(A) MCEs shall only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the MCE by the Authority in encounter claims:

(i) The National Provider Identifiers (NPI) for a provider covered entity enrolled with the Authority; or

(ii) The Oregon Medicaid proprietary provider numbers for the Authority enrolled non-covered atypical provider entities.

(B) MCEs shall make an adjustment to any encounter claim within 30 days of discovering the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed;

(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) below, the MCE must adjust or void the encounter claim within 30 days of notification by the Authority of the required action or as identified in paragraph (E) below;

(D) If the Authority discovers errors with a previously adjudicated encounter claim resulting from a federal or state mandate or request that requires the completeness and accuracy of the encounter data, the MCE must correct the errors within a timeframe specified by the Authority;

(E) If circumstances prevent the MCE from meeting requested timeframes for correction, the MCE may contact the Authority to determine an agreed upon specified date except as required in subsection (4)(c)(Dd) below;

(F) MCEs retain liability for certifying encounter data as complete, truthful, and accurate. MCEs must ensure claims data received from providers, either directly or through a third-party submitter, is accurate, truthful, and complete by:

(i) Verifying accuracy and timeliness of reported data;

(ii) Screening data for completeness, logic, and consistency;

(iii) Submitting a complete and accurate Encounter Data Certification and Validation Report available on the Authority's website.

(G) MCEs shall make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.

(c) Encounter Claims Data Corrections for "must correct" Encounter Claims:

(A) The Authority shall notify the MCE of the status of all encounter claims processed;

(B) Notification of all encounter claims processed that are in a "must correct" status shall be provided by the Authority to the MCE each week and for each subsequent week the encounter claim remains in a "must correct" status;

(C) The Authority may not necessarily notify the MCE of other errors; however, this information is available in the MCE's electronic remittance advice supplied by the Authority;

(D) MCEs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the MCE notice that the encounter claim remains in a “must correct” status;

(E) MCEs may not delete encounter claims with a “must correct” status as specified in section (3)(d) except when the Authority has determined the encounter claim cannot be corrected or for other reasons.

(5) Electronic Health Records (EHR) Systems OAR 410-165-0000 to 410-165-0140. In support of an eligible provider’s ability to demonstrate meaningful use as an EHR user, as described by 42 CFR 495.4 and 42 CFR 495.8, the MCE must:

(a) Submit encounter data in support of a qualified EHR user’s meaningful use data report to the Authority for validation as set forth in OAR 410-165-0080;

(b) Respond within the timeframe determined by the Authority to any request for:

(A) Any suspected missing MCE encounter claims, or;

(B) MCE-submitted encounter claims found to be unmatched to an EHR user’s meaningful use report.

(6) MCEs shall comply with the following hysterectomy and sterilization standards as described in 42 CFR 441.250 to 441.259 and the requirements of OAR 410-130-0580:

(a) MCEs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of the date of service; or immediately upon notification by the Authority that a qualifying encounter claim has been identified;

(b) The Authority in collaboration and cooperation with the MCE shall reconcile all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:

(A) Confirming the validity of the consent and notifying the MCE that no further action is needed;

(B) Requesting a corrected informed consent form, or;

(C) Informing the MCE, the informed consent is missing or invalid and the payment must be recouped, and the associated encounter claim must be changed to reflect no payment made for services within the timeframe set by the Authority.

(7) Upon request by the Authority, MCEs shall furnish information regarding rebates for any covered outpatient drug provided by the MCE as follows:

(a) The Authority is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8) as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) for any covered outpatient drug provided by the MCE, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;

(b) MCEs shall report prescription drug data as specified in section (3)(b).

(8) Encounter Pharmacy Data Rebate Dispute Resolution as governed by SSA Section 1927 42 U.S.C. 1396r-8 and as required by OAR 410-121-0000 through 410-121-0625. When the Authority receives an Invoiced Rebate Dispute from a drug manufacturer, the Authority shall send the Invoiced Rebate Dispute to the MCE for review and resolution within 15 days of receipt:

(a) The MCE shall assist in the dispute process as follows:

(A) By notifying the Authority that the MCE agrees an error has been made; and

(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 days of receipt of the Invoiced Rebate Dispute.

(b) If the MCE disagrees with the Invoiced Rebate Dispute that an error has been made, the MCE shall send the details of the disagreement to the Authority's encounter data liaison within 45 days of receipt of the Invoiced Rebate Dispute.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: 414.610 - 414.685

**410-141-3585 MCE Member Relations: Education and Information (Proposed Changes For 1/1/21)**

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. 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 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access intensive care coordination (ICC) Services, and where applicable for full benefit dual eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305and 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 education materials shall comply with the following language and access requirements:

(a) Materials shall be translated or include taglines in the prevalent non-English languages in the state as well as large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;

(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings;

(c) Electronic versions of member materials shall be made available on 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 include:

(a) The provider's name as well as any group affiliation;

(b) Street address;

(c) Telephone number;

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

(g) Whether the provider offers both telehealth and in-person appointments;

(hg) Information about the provider's cultural and linguistic capabilities including:

(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;

(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and

(C) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in 410-141-3735 whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);

(D) 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 providers' offices, exam rooms, restrooms, and equipment.

(lh) 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.

(ji) Information included in the provider directory must be updated at least monthly, and electronic provider directories must 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;

(kj) 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.

(7) Within 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.

(8) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.

(9) 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 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and

(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.

(10) 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. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in alternate formats;

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

(d) 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 MCE's policy on changing PCPs;

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

(f) Which participating or non-participating provider services the member may self-refer;

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

(h) Explanation of ICC services and how eligible members may access those services;

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

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

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

(L) Information on contracted hospitals in the member's service area;

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

(n) Information on the MCE'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 MCE to the member as outlined in OAR 410-141-3875;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3885.

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

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

(q) 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;

(r) The 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 specific communications for members who are becoming new Medicare enrollees;

(s) 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 MCE's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(t) Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives;

(u) 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;

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

(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

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

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

(aa) The MCE's confidentiality policy;

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

(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs;

(dd) MCEs 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 MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members;

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

(11) 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 may 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 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 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.

(12) 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, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685
History:
DMAP 55-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3715 CCO Governance; Public Meetings and Transparency**
**(Proposed Change for 1/1/21)**

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council (CAC) that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) Consumer Representative means a person serving on a CAC who is currently or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian, or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(3) Each CCO's governing body must include:

(a) At least one member representing persons that share in the financial risk of the organization;

(b) A representative of a dental care organization selected by the coordinated care organization;

(c) The major components of the health care delivery system;

(d) At least two health care providers in active practice, including:

(A) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

(B) A mental health or chemical dependency treatment provider.

(e) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(f) At least two members of the CAC:

(A) At least one of the CAC representatives on the CCO's governing body must be a current CAC Consumer Representative;

~~(B) Any CAC member serving on a CCO governing board must disclose any conflicts of interest;~~

(B~~C~~) CAC members of the governing body shall have full voting rights.

(4) For purposes of the open meetings requirement in Section 2 of Enrolled 2018 HB 4018, 2018 Oregon Laws Chapter 49, "substantive decision" means a decision made by the governing board of a coordinated care organization (CCO) that relates to:

(a) Spending of public funds;

(b) The financial risk of the CCO;

(c) Provider network development and capacity; or

(d) The community advisory council, community health assessment, or community health improvement plan.

(5) Substantive decision does not require or include:

(a) Disclosure of trade secrets as defined in ORS 192.345;

(b) Confidential communications with a lawyer that are privileged under ORS 40.225;

(c) Information of a personal nature as described in ORS 192.355;

(d) Protected health information as defined in ORS 192.556;

(e) Names of Oregon Health Plan consumer members of a community advisory council who request to remain anonymous;

(f) Confidential human resource matters; or

(g) Provider credentialing, sanctioning, or termination.

(6) The term “substantive decision” excludes immaterial technical decisions.

Statutory/Other Authority: ORS 413.042, ORS 414.615 & ORS 414.625
Statutes/Other Implemented: Oregon laws 2018 Chapter 49

**410-141-3730 Community Health Assessment and Community Health Improvement Plans**

**(Proposed Changes Effective 1/1/21)**

(1) CCOs shall comply with the requirements in ORS 414.627 and 414.629, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.

(2) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.

(3) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-E partners, as defined in OAR 410-141-3735;

(d) Local mental health authorities and community mental health programs;

(e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

(g) Indian Health Care Providers;

(h) Traditional Health Workers;

(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions; and

(k) Representatives from populations who are experiencing health and health care disparities.

(4) The CHA must include or identify and analyse at a minimum, all of the following:

(a) The demographics of all of the Communities within Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, sex, gender identity, and sexual orientation. CCOs shall work with community organizations and available data sources to obtain information on gender identity and sexual orientation if it is available;

(b) The health status and issues of all the Communities within Contractor's Service Area;

(c) The health disparities among all of the Communities within Contractor's Service Area;

(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;

(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);

(f) Assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:

(A) Access to primary prevention resources;

(B) Disproportionate, unmet, health-related needs;

(C) Description of assets within the Community that can be built on to improve the Community's health;

(D) Systems of seamless continuum of care; and

(E) Systems or programs of collaborative governance of community benefit.

(g) Means to promote the health and early intervention in the treatment of children and adolescents within Contractor's Service Area, and whether they are sufficient and effective;

(h) Areas for improvement; and

(i) The persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.

(5) CCOs and their CACs must develop baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, neighborhood and environment, or other factors. This data will be used to identify and prioritize strategies to reduce health disparities in the development of their CHPs.

(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).

(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP. The CCOs' CACs are responsible for adopting CHPs.

(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and

stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-E partners, as defined in OAR 410-141-3735;

(d) Local mental health authorities and community mental health programs;

(e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

(g) Indian Health Care Providers;

(h) Traditional Health Workers;

(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions; and

(k) Representatives from populations who are experiencing health and health care disparities.

(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.

(a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:

(A) Closing the gap on disproportionate, unmet, health-related needs;

(B) Creating access to primary prevention;

(C) Building a system of seamless continuum of care;

(D) Building on current Community resources and improving Community capacity to improve health or address SDOH-E, or both; and

(E) Engaging the Community in the implementation of the CHP.

(b) The CHP strategies should be based on research and may include, without limitation:

(A) Developing a or supporting Health Policy that supports the CHP goals and objectives;

(B) Implementing or supporting community health or SDOH-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

(C) Developing public and private resources and capacities;

(D) Designing and building a system of Integrated service delivery;

(E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.

(c) The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies;

(d) The CHP must also address, with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the needs of adolescents and children in a CCO's Service Area and must address:

(A) Findings based on research, including adverse childhood experiences;

(B) The adequacy of existing school-based health center (SBHC) networks and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community;

(C) The integration of all services provided to meet the needs of children, adolescents, and families; and

(D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.

(10) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and improving health equity. Progress reports will be submitted in the manner and form proscribed by OHA.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

History:

DMAP 56-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3730 Community Health Assessment and Community Health Improvement Plans**

**(Proposed Changes Effective 1/1/21)**

(1) CCOs shall comply with the requirements in ORS 414.627 and 414.629, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.

(2) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.

(3) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-E partners, as defined in OAR 410-141-3735;

(d) Local mental health authorities and community mental health programs;

(e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

(g) Indian Health Care Providers;

(h) Traditional Health Workers;

(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions; and

(k) Representatives from populations who are experiencing health and health care disparities.

(4) The CHA must include or identify and analyse at a minimum, all of the following:

(a) The demographics of all of the Communities within Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, sex, gender identity, and sexual orientation. CCOs shall work with community organizations and available data sources to obtain information on gender identity and sexual orientation if it is available;

(b) The health status and issues of all the Communities within Contractor's Service Area;

(c) The health disparities among all of the Communities within Contractor's Service Area;

(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;

(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);

(f) Assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:

(A) Access to primary prevention resources;

(B) Disproportionate, unmet, health-related needs;

(C) Description of assets within the Community that can be built on to improve the Community's health;

(D) Systems of seamless continuum of care; and

(E) Systems or programs of collaborative governance of community benefit.

(g) Means to promote the health and early intervention in the treatment of children and adolescents within Contractor's Service Area, and whether they are sufficient and effective;

(h) Areas for improvement; and

(i) The persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.

(5) CCOs and their CACs must develop baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, neighborhood and environment, or other factors. This data will be used to identify and prioritize strategies to reduce health disparities in the development of their CHPs.

(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).

(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP. The CCOs' CACs are responsible for adopting CHPs.

(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and

stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-E partners, as defined in OAR 410-141-3735;

(d) Local mental health authorities and community mental health programs;

(e) Physical, behavioral, and oral health care providers;

(f) Federally Qualified Health Centers;

(g) Indian Health Care Providers;

(h) Traditional Health Workers;

(i) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions; and

(k) Representatives from populations who are experiencing health and health care disparities.

(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.

(a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:

(A) Closing the gap on disproportionate, unmet, health-related needs;

(B) Creating access to primary prevention;

(C) Building a system of seamless continuum of care;

(D) Building on current Community resources and improving Community capacity to improve health or address SDOH-E, or both; and

(E) Engaging the Community in the implementation of the CHP.

(b) The CHP strategies should be based on research and may include, without limitation:

(A) Developing a or supporting Health Policy that supports the CHP goals and objectives;

(B) Implementing or supporting community health or SDOH-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

(C) Developing public and private resources and capacities;

(D) Designing and building a system of Integrated service delivery;

(E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.

(c) The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies;

(d) The CHP must also address, with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the needs of adolescents and children in a CCO's Service Area and must address:

(A) Findings based on research, including adverse childhood experiences;

(B) The adequacy of existing school-based health center (SBHC) networks and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community;

(C) The integration of all services provided to meet the needs of children, adolescents, and families; and

(D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.

(10) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and improving health equity. Progress reports will be submitted in the manner and form proscribed by OHA.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

History:

DMAP 56-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3735 Social Determinants of Health and Equity; Health Equity**

**(Proposed Changes Effective 1/1/21)**

(1) This rule defines health disparities and the social determinants of health and equity (SDOH-E), establishes requirements for the Supporting Health for All through Reinvestment Initiative (SHARE Initiative), establishes the role of the Community Advisory Councils in supporting SDOH-E, establishes requirements for collecting data on race, ethnicity, and primary language, and establishes requirements for developing health equity infrastructure within a Coordinated Care Organization (CCO). This rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.

(2) The following definitions apply for purposes of this rule:

(a) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the indicators used to track progress toward achieving health equity.

(b) "Social Determinants of Health and Equity" (SDOH-E):

(A) SDOH-E encompasses three terms:

(i) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities;

(ii) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities;

(iii) Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.

(B) SDOH-E initiatives may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:

(i) Community-level interventions that directly address social determinants of health or social determinants of equity;

(ii) Interventions to address individual health-related social needs.

(c) "SDOH-E Partner" is a single organization, local government, one or more of the Federally-recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area.

(3) The following requirements are specific to the Supporting Health for All through Reinvestment Initiative (SHARE Initiative):

(a) For each calendar year starting on or after January 1, 2021, CCOs shall dedicate a portion of their previous calendar year's net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018) and as set forth in the contract;

(b) CCOs shall select SDOH-E spending priorities that fall into at least one of four domains of SDOH-E: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health, and are consistent with:

(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs; and

(B) Any SDOH-E priority areas identified by the Authority.

(c) A portion of SHARE Initiative dollars must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract, a Memorandum of Understanding, or other form of agreement including a grant agreement, with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO.

(d) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.

(4) Community Advisory Councils (CAC):

(a) CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on ~~SDOH-E, including~~ the SHARE Initiative;

(b) CCOs shall designate a rolle for the CAC in, ~~and~~ health-related services community benefit initiative~~s~~ spending decisions,, as defined in OAR 410-141-3845.

(c) CCOs shall have a conflict of interest policy that applies to its CAC members and accounts for financial interests related to potential health-related services, Share Initiative, or other SDOH-E spending;

(d~~b~~) CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues. These reports will be posted publicly with appropriate redactions.

(5) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.

(6) Health Equity Infrastructure:

(a) The term “Health equity infrastructure” refers to the adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality language access; workforce diversity; ADA compliance and accessibility of CCO and provider network; ACA 1557 compliance; CCO and provider network organizational training and development; implementation of the CLAS Standards; non-discrimination policies;

(b) The “Health Equity Plan" is part of the "Health Equity Infrastructure;"

(c) CCOs shall develop and implement the “Health Equity Plan” to embed health equity as a value and business practice into organizational policies, procedures, and processes; meet state and federal laws and contractual obligations regarding accessibility and culturally and linguistically responsive health care and services; inform using an equity framework in all policy, operational, and budget decisions; provide a structure to ensure oversight and management of programs and services with the goal to advance health equity and provide culturally and linguistically appropriate services. The health equity plan shall include the following:

(A) Narrative of the health equity plan development process, including description of meaningful community engagement;

(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics;

(C) Organizational and Provider Network Cultural Responsiveness and Implicit Bias training plan:

(i) CCO shall incorporate Cultural Responsiveness and implicit bias continuing education and training into its existing organization-wide training plan and programs;

(ii) CCO shall align cultural responsiveness and implicit bias trainings with the “Cultural Competence Continuing Education” criteria developed by the Authority’s Cultural Competence Continuing Education Advisory Committee referenced in OAR 943-090-0020;

(iii) CCO shall adopt the definition of Cultural Competence set forth in OAR 943-090-0010;

(iv) CCO shall provide and require all its employees, including directors, executives, and CAC members to participate in all such trainings;

(v) CCO’s shall require all of the CCO’s Provider Network to comply with Cultural Competency Continuing Education requirements set forth in ORS 676.850.

(d) The health equity plan and the language access self-assessment report are required to be submitted under OAR 410-141-3515 and shall be submitted every year to the Authority for review and approval;

(e) CCOs shall designate a Single Point of Accountability. The single point of accountability can also be called the Health Equity Administrator:

(A) The Single Point of Accountability ("Health Equity Administrator") shall be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network and CCO service area;

(B) The Single Point of Accountability ("Health Equity Administrator”) shall have budgetary decision-making authority and health equity expertise;

(C) The Single Point of Accountability (“Health Equity Administrator") shall be a high-level employee (e.g., director level or above) and can have more than one area of responsibility and job title;

(D) The CCO shall inform and describe to the authority any changes related to the “Health Equity Administrator” role or scope using the Health Equity Plan;

(E) The Single Point of Accountability ("Health Equity Administrator") shall have the authority to communicate directly with CCO executives and governing board.

Statutory/Other Authority: ORS 414.615, 414.625, 413.042, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

History:

DMAP 56-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3820 Covered Services (Proposed Changes Effective 1/1/21)**

(1) General standard. The OHP Benefit Package includes treatments and health services which pair together with a condition on the same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified in any relevant Statements of Intent and Guideline Notes of the Prioritized List of Health Services. The Benefit Package also covers the additional services described in this rule.

(a) As used in OAR 410-141-3820 and 410-141-3825, the word "health services" has the meaning given in ORS 414.025(13);

(b) Services are covered with respect to an individual member only when the services are medically or orally necessary and appropriate as defined in 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ORS 743A.012;

(c) Benefit Package coverage of prescription drugs is discussed in OAR 410-141-3855;

(d) The Benefit Package is subject to the exclusions and limitations described in OAR 410-141-3825.

(2) MCE service offerings:

(a) MCEs shall offer their members, at a minimum:

(A) The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the MCE's mandatory scope of services; and

(B) Any additional services required in OAR chapter 410, or in the MCE contract.

(b) CCOs shall coordinate physical health, behavioral health and oral health care benefits;

(c) With respect to members who are dually eligible for Medicare and Medicaid, MCEs shall provide:

(A) OHP Benefit Package services except for Medicaid-funded long-term care, services, and supports; and

(B) Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan.

(3) Diagnostic services. Diagnostic services that are medically or orally appropriate and medically or orally necessary to diagnose the member's presenting condition (signs and symptoms) or guide management of a member's condition, regardless of whether the condition appears above or below the funded line on the Prioritized List of Health Services. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines on the Prioritized List of Health Services.

(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services. Preventive Services are included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, as specified in related guideline notes. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

(6) Ancillary services. Ancillary services are covered subject to the service limitations of the OHP program rules when:

(a) The services are medically or orally necessary and appropriate in order to provide a funded service; or

(b) The provision of ancillary services will enable the member to retain or attain the capability for independence or self-care;

(c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines on the Prioritized List of Health Services.

(7) SUD services. The provision of SUD services shall comply with OAR 410-141-3545.

(8) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k.

(9) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in 410-130-0245.

(10) Coverage of services for unfunded conditions based on effect on funded comorbid conditions:

(a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:

(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.

(b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (10);

(c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis;

(d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:

(A) Treating health care provider opinion;

(B) Medical research; and

(C) Current peer review.

(11) Ensuring that all coverage options are considered:

(a) When a provider receives a denial for a non-covered service for any member, especially a member with a disability or with a co-morbid condition, the provider shall determine whether there may be a medically appropriate covered service to address the member's condition or clinical situation, before declining to provide the non-covered service. The provider's determination shall include consideration of whether a service for an unfunded condition may improve a funded comorbid condition under subsection (10~~8~~);

(b) If a member seeks, or is recommended, a non-covered service, providers shall ensure that the member is informed of:

(A) Clinically appropriate treatment that may exist, whether covered or not;

(B) Community resources that may be willing to provide the relevant non-covered service;

(C) If appropriate, future health indicators that would warrant a repeat evaluation visit.

(c) Before an MCE denies coverage for an unfunded service for any member, especially a member with a disability or with a co-morbid condition, the MCE shall determine whether the member has a funded condition or condition/treatment pair that would entitle the member to coverage under the program.

(12) Assistance to providers. The Authority shall maintain a telephone information line for the purpose of assisting practitioners in determining coverage under the OHP Benefit Package. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Authority shall make a retrospective determination under this section, provided the Authority is notified of the emergency situation during the next business day. If the Authority denies a requested service, the Authority shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(13) Ad hoc coverage determinations.

~~(a) If a member seeks a service pertaining to a funded condition and a funded or unfunded treatment that does not pair with the same condition on the HERC Prioritized List of Health Services, and coverage is not otherwise available pursuant to this rule, or excluded by any applicable statute, and the member requests an appeal from their MCE or a hearing from fee for service, the MCE or Division must make an ad hoc determination on an individual basis as to whether the treatment may be medically or orally appropriate and necessary for the member;~~

(a~~b~~) When a~~If the~~ member requests a hearing pertaining to a funded condition and a funded or unfunded treatment that does not pair on the HERC Prioritized List of Health Services and the treatment is not included in guideline note 172 or 173 of the prioritized list, before the hearing the Division shall determine if the requested treatment is appropriate and necessary for the member.

(b) For treatments determined to be appropriate and necessary under (a) in this section, the Division determines whether the HERC has considered the funded condition/treatment pair for inclusion on the Prioritized List within the last five years. If the HERC has not considered the pair for inclusion within the last five years, the Division shall make an ad hoc coverage determination in consultation with the HERC.

(c) For treatments determined to not be appropriate and necessary under (a) in this section the hearing process shall proceed. ~~:~~

~~(c) Ad hoc determination of individual cases is based on the Division's assessment of whether the treatment is medically appropriate and necessary for the patient and meets the other relevant rules and program standards. Ad hoc determinations shall include consideration of the patient's medical history, the treating provider's recommendation, available medical research and professional guidelines. Ad hoc determinations may be informed by consultations with specialists with relevant expertise on the condition or treatment in question;~~

~~(A) If the Division determines that the requested treatment is not appropriate and necessary, the Division will uphold the denial. The member may then proceed to hearing;~~

~~(B) If the Division determines that the requested treatment is appropriate and necessary for the member's condition, the Division will overturn the denial and approve the coverage by exception. This determination will not need to proceed to hearing.~~

~~(d) If the Division hearing overturns a MCE's coverage determination, the MCE may invoke the dispute resolution procedures in OAR 410-141-3550.~~

(14) General anesthesia for oral procedures. General anesthesia for oral procedures that are medically and orally necessary and appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

**410-141-3830 Prioritized List of Health Services (Proposed Changes Will Be Discussed at 8/12/20 RAC)**

(1) The Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and behavioral health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their website: https://www.oregon.gov/OHA/HPA/DSI-HERC/Pages/Prioritized-List.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule, effective March 15, 2020, incorporates by reference the January 1, 2020 Prioritized List, funded through line 471 and including all line items, diagnosis and treatment codes, guideline notes, statements of intent, coding specifications and annotations. The Prioritized List dated March 13, 2020 supersedes the January 1, 2020 Prioritized List for services provided after March 13, 2020, and includes interim modifications reported as required under ORS 414.690(7) and (8).

Statutory/Other Authority: ORS 413.042 & ORS 414.065

Statutes/Other Implemented: ORS 414.065 & ORS 414.727

History:

DMAP 8-2020, temporary amend filed 03/15/2020, effective 03/15/2020 through 09/10/2020

DMAP 56-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3845 Health-Related Services (Proposed Changes Effective 1/1/21)**

(1) The goals of health-related services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services:

(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below;

(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;

(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;

(d) HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 45 C.F.R. § 158.150:

(a) The service must be designed to:

(A) Improve health quality;

(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(D) Be based on any of the following:

(i) Evidence-based medicine; or

(ii) Widely accepted best clinical practice; or

(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;

(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(D) Implement, promote, and increase wellness and health activities;

(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(c) The following types of expenditures and activities are not considered HRS:

(A) Those that are designed primarily to control or contain costs;

(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;

(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;

(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;

(F) All retrospective and concurrent utilization review;

(G) Fraud prevention activities;

(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(I) Provider credentialing;

(J) Costs associated with calculating and administering individual member incentives; and

(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.

(3) CCOs shall implement policies and procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval:

(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability;

(b) A CCO's HRS spending on community benefit initiatives shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any HRS community benefit initiative spending priorities identified by the Authority;

(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in community benefit initiatives spending decisions;

(d) CCOs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.

(4) Flexible services are cost-effective services offered to an individual member as an adjunct to covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care. These services shall be documented in the member's treatment plan and clinical record:

(a) CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;

(b) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915.

(5) Community benefit 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 ~~directing, tracking, and reviewing~~ health-related services community benefit initiatives, as provided in OAR 410-141-3735.

(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).

(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 413.042

History:

DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3860 Integration and Coordination of Care (Proposed Changes Effective 1/1/21)**

(1) In order to achieve the objectives of providing CCO members integrated person-centered care and services, CCOs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs shall be required to document and report on the requirements in this rule in accordance with section (20) of this rule.

(2) CCOs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.

(3) CCOs shall coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:

(a) With the services the member receives from any other CCO, and for FBDE members, from Medicare providers and, where applicable, MA or DSNP plans;

(b) With the services the member receives in FFS Medicaid; and

(c) With the services the member receives from community and social support providers.

(4) CCOs shall develop evidence-based and, whenever possible, innovative flexible and creative strategies, for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.

(5) To the maximum extent feasible, CCOs shall develop and use patient-centered primary care home (PCPCH) capacity by implementing a network of PCPCHs by:

(a) Making PCPCHs the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) Developing and implementing mechanisms that encourage providers to communicate and coordinate care with PCPCHs in a timely manner, using electronic health information technology when the technology is available; and

(c) Engaging other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.

(6) If, in addition to the use of PCPCH, a CCO implements other models of patient-centered primary health care, the CCO shall ensure member access to effective coordinated care services that include wellness and prevention services, active management and support of members with special health care needs, including those members receiving Medicaid long-term services and supports (LTSS), a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. To that end the CCO shall be required to:

(a) Ensure each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type. If the member does not choose a primary care provider or primary care team within 30 calendar days from the date of enrollment, the CCO shall ensure the member has an ongoing source of primary care appropriate to their needs by formally designating a practitioner or entity. CCOs shall document in each member's case file all efforts made in accordance with this subsection (a);

(b) Ensure that each member has an ongoing source of care appropriate to their needs, including regular access to specialty care for members with chronic conditions or disabilities, and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided with information on how to contact their designated person or entity;

(c) Develop services and supports for primary and behavioral health care that meet the access to care requirements set forth in OAR 410-141-3515 and which are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall also ensure that all other services and supports meet the access to care requirements set forth in OAR 410-141-3515; and

(d) Allow eligible members who are American Indian/Alaska Native to select as their primary care provider:

(A) An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or

(B) An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.

(7) MCEs shall establish and enter into hospital and specialty service agreements that include the role of PCPCHs and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for after-hospital follow up appointments.

(8) CCOs shall meet all of the following requirements relating to transitions of care:

(a) Require hospitals and specialty services to be accountable for achieving successful transitions of care;

(b) Ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings and provided the supportive services needed to ensure successful transition. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, skilled nursing or other long term care settings, and the State Hospital;

(c) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service to a CCO, the CCO shall make every reasonable effort within the laws governing

confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an CCO participating provider;

(d) Implement systems to assure and monitor transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve members' experience of care and outcomes,

particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the processes for members accessing care coordination;

(e) For members who are discharged to post hospital extended care by being admitted to skilled nursing facility (SNF), the CCO shall notify the appropriate Department office and coordinate appropriate discharge planning and ensure services are in place prior to discharge. The CCO shall pay for the full 20-day post-hospital extended care benefit when the full 20 days is required by the discharging provider, if the member was enrolled in the CCO during the hospitalization preceding the nursing facility placement:

(A) CCOs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC) that the post-hospital extended care will be paid for by the CCO;

(B) For members who are discharged to Medicare Skilled Care Unit within a SNF, the CCO shall notify the appropriate Department office when the CCO learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care; and

(C) CCOs shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.

(f) CCOs shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs (as defined under OAR 309-032-0860(30)) between levels or episodes of

care. Specific requirements for CCO care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.

(9) CCOs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs as follows:

(a) Establishing procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;

(b) Developing and entering into memoranda of understanding (MOUs) or contracts with the local type B Area Agency on Aging or the local office of the Department's APD that details their system coordination agreements regarding members receiving Medicaid-funded LTCSS; and

(c) Developing and entering into MOUs or contracts with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget. For FBDE members, MCEs shall coordinate Medicare covered behavioral health benefits and Medicaid behavioral health benefits to ensure members receive appropriate and medically necessary care, including preventative screenings and assessments.

(10) CCOs shall cover and reimburse inpatient psychiatric services, except when those services are provided at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010 and OAR 410-141-3500. The state may, however, make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services provided at an IMD as an alternative setting to those covered under the state plan, when all of the following requirements are met in accordance with 42 CFR 438.6(e):

(a) The member receiving services is aged 21-64;

(b) The services are provided for a short-term of no more than 15 days during the period of the monthly capitation payment; and

(c) The provision of services at the IMD meets the requirements for "in lieu of services" as set forth in 42 CFR 438.6(e)(2)(i) through (iii), which requires all of the following:

(A) The IMD is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;

(B) The CCO must offer members the option to access the state plan services and shall not require members to use the IMD as an alternative service or setting; and

(C) The approved in lieu of services are authorized and identified in the CCO contracts and offered to members at the CCO's option.

(11) If a member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, the CCO shall communicate with the member, the member's representative, and the Medicaid funded long-term care provider or facility, and the DHS or AAA case manager about integrated and coordinated care services.

(12) CCOs shall ensure their participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. The CCOs shall also ensure that they facilitate information exchanges between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). Compliance with the requirements under this section (12) shall be documented and reported to the Authority in the form and manner required by the Authority in accordance with OAR 410-141-3525:

(a) CCOs shall require that providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with their Health Equity Plan Training and Education described in 410-141- 3735;

(b) CCOs shall communicate their integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(13) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. CCOs shall coordinate the care of members who enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the Oregon State Hospital and when they are transitioning out of the Oregon State Hospital.

(14) Except as provided in OAR 410-141-3800, CCOs shall coordinate a member's care outside the CCO's service area or, when medically necessary specialty care is not available in Oregon, out-of-state care. CCOs shall coordinate member care even when services or placements are outside the CCO service area. Temporary placements by the Authority, Department, or providers who are responsible for health service placements for services including residential placements, may be located outside the service area; however, the CCO shall coordinate care while in placement and discharge planning for return to the home CCO. For out of service area placements, an exception shall be made for the member to retain home CCO enrollment while the member's placement is a temporary residential placement elsewhere. ~~:~~

~~(a)~~ CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan when the member returns to their home CCO.~~; or~~

(15) CCOs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area,

out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay for the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 CCO Service Authorization.

(16) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing behavioral health crises and to prevent inappropriate use of the emergency department or jails.

(17) CCOs shall perform care coordination in a manner that is trauma-informed, ~~and~~ culturally responsive, and which promotes dignity for individuals with disabilities or chronic conditions, as those terms are defined in OAR 410-141-3500.

(18) CCOs shall implement at least one outcome measure tool for care coordination services at the ICC Care Coordination level. CCOs shall collaborate with the Authority to develop statewide standards for care coordination and ICC.

(19) CCOs shall monitor and document their care coordination activities and the effectiveness of those efforts in a report submitted to the Authority semi-annually beginning in the second half of 2021. Beginning in 2022, CCOs shall submit reports semi-annually on June 30th and December 31st. The CCO is subject to appropriate corrective action by the Authority if the contents of the report reveal that the CCO's care coordination requirements are not being met. For each reporting period the report must contain:

(a) Identification of care coordination practices used with members and the frequency with which each of those practices were used;

(b)Identification of the number of members who qualify for ICC services

(c~~b~~) Identification of the number of members receiving ICC services, the type of ICC services provided, and the demographics of such members;

(dc) An overall review of care coordinators performing services for the CCO, separated by employed and delegated or subcontracted care coordinators;

(ed) Identification of any significant events that occurred to members, including, without limitation:

(A) Incarceration;

(B) Reassessment triggers; and

(C) Sentinel events. For the purpose of this rule, Sentinel Event is defined as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.;

(fe) Data on the type and frequency of reassessment triggers;

(gf) Identification of the number of members who received services in coordination with MA or DSNP plans and Medicaid funded LTSS programs and services;

(hg) Plans and strategies to improve care coordination with network providers;

(ihg) ~~Reports of member grievances related to care coordination with corrective action plans to improve common grievances;~~

(jih) Identification of milestones and accomplishments; and

(kji) A plan to improve the overall process of care coordination access for its Members. The plan shall also include discussion of gaps in care coordination services and populations that need additional support and plans for improving the care coordination system within their CCO. The plan is subject to approval by the CCOs' governing boards.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610–414.685

**410-141-3865 Care Coordination Requirements (Proposed Changes Effective 1/1/21)**

(1) CCOs will ensure continuous care management for all members.

(2) For the purpose of OARS 410-141-3860 – 410-141-3870, the following meanings apply;

(a) "Health Risk Screening" means:

(A) a systematic approach to collecting information from a Member about key areas of their health for the purpose of:

(i) Assessing the Member's health,

(ii) Evaluating the Member's level of health risk, and

(B) Providing the Member with individualized feedback about the results of the screening and evaluation with the goal of motivating behavioral changes to reduce health risks, maintain health, and prevent disease.

(C) Health Risk Screenings are usually administered through a survey or questionnaire and include questions, depending on the Member's age, regarding:

(i) Demographics (e.g. age, gender, relationship status),

(ii ) Lifestyle behaviors (e.g. exercise, eating habits, alcohol and tobacco use, activities of daily living),

(iii) Living Conditions (access to food, housing and related living conditions),

(iv) Behavioral/emotional health (e.g. stress, mood, life events, abuse),

(v) Physical health (e.g. weight, height, blood pressure), and

(vi) Personal and family health history."

(b) "Intensive Care Coordination (ICC) Assessment" means the utilization of standardized tools, instruments, or processes for the purpose of identifying, and creating induvial, personalized treatment and service plans to address, the specific physical, behavioral, oral, and social needs of Priority Population Members, as well as other Members who have been identified, as a result of their Health Risk Screenings, as potentially in need of ICC Services, or having experienced a triggering event as set forth in OAR 410-141-3870(9).

(3~~2~~) CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member in accordance with OAR 410-141-3870. This screening is distinct from the assessment of special health care needs:

(a) CCOs must use a universal screening process to evaluate all members for critical risk factors that trigger the need for intensive care coordination for members with special health care needs;

(b) Members shall be screened upon initial enrollment with their CCO. This screening shall be completed as follows:

(A) Within 90 days of the effective date of initial enrollment;

(B) Within 30 days of the effective date of initial enrollment when the member is:

(i) Referred; or

(ii) Receiving Medicaid-funded long-term care, services and supports (LTSS); or

(iii) Is a member of a priority population as such term is defined in OAR 410-141-3870(2); or

(C) Sooner than required under (A) or (B) if required by the member's health condition.

(c) CCOs shall rescreen members annually or sooner if there is a change in health status indicating need for an updated assessment. Members shall be rescreened in accordance with this section (c) even if they have previously declined care coordination or ICC services;

(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;

(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.

(43) CCOs shall document all screenings and assessments in the member's case file:

(a) If a CCO requires additional information from the member to complete a screening or assessment, the CCO shall document all attempts to reach the member by telephone and mail;

(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;

(c) CCOs shall share the results of member assessments and screenings consistent with ORS 414.679 and all other applicable state and federal privacy laws with the following:

(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;

(B) The state or other MCEs serving the member;

(C) Members receiving LTSS and, if approved by the member, their case manager and their LTSS provider, if approved by the member; and

(D) With Medicare Advantage or DSNP plans serving dual eligible members.

(54) CCOs shall have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and for identifying those members requiring referral to the Department for LTSS.

(65) CCOs shall require their care coordinators shall develop, and CCOs shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ICC needs, including those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving LTSS.

(76) A member's care plan must at a minimum:

(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners;

(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member;

(c) Make provision for authorization of services in accordance with OAR 410-141-3835;

(d) For members enrolled in ICC or a condition-specific program, intensive care coordination plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care needs change.

(8~~7~~) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:

(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;

(b) To ensure engagement and satisfaction with care plans, care coordinators shall:

(A) Actively engage members in the creation of care plans;

(B) Ensure members understand their care plans; and

(C) Ensure members understand their role and responsibilities outlined in their care plans.

(c) Care coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities;

(d) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as above;

(e) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providing the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above.

(9~~8~~) A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

(10~~9~~) Care coordinators shall perform their care coordination tasks in accordance with the following principles:

(a) Use trauma informed, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-being;

(b) Work with members to set agreed-upon goals with continued CCO network support for self-management goals;

(c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;

(d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;

(e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;

(f) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and

(g) Have contact with, if the member is participating in a condition-specific program, the active condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

(11~~0~~) Care coordinators shall promote continuity of care and recovery management through:

(a) Episodes of care, regardless of the member's location;

(b) Monitoring of conditions and ongoing recovery and stabilization;

(c) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and

(d) Engaging members, and their family and caregivers as appropriate.

(e) For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.

(12~~1~~) CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below.

(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities.

(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:

(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;

(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and

(C) Engage with the member, face to face, within two days post discharge.

(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on a face-to-face basis whenever possible, as follows:

(A) Within one business day of admission;

(B) Two times per week while the member is in acute care; and

(C) No less than two times per week within the week of discharge.

(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;

(e) In the event a member has a lapse in Medicaid coverage while admitted to a hospital, residential, inpatient, long-term care, or other similarly licensed in-patient facility, CCOs must also, in addition to providing the services set forth in subsections (a)-(d) of this section (11) of this rule, oversee management of the member's care, work to establish services that may be needed but currently are not available in their service areas, and if eligible, assist in the reinstatement of Medicaid coverage. The CCO's obligation to provide such services shall continue for the period of 60 days from the date the member lost Medicaid coverage or until the member's discharge, whichever occurs sooner.

(13~~2~~) CCOs shall ensure care coordinators are providing the required and appropriate behavioral, oral, and physical health care services and supports to members. The individual(s) tasked with responsibility for supervising care coordinators, whether employed by a CCO or employed by a Subcontractor providing care coordination services, shall be a licensed master's-level mental health professional. CCOs shall not subcontract or otherwise delegate the responsibility for ensuring any subcontracted care coordination services and activities meet the requirements set forth in this rule, OARs 410-141-3860, 410-141-3870, and any other applicable care coordination requirements.

Statutory/Other Authority: 414.615, 414.625, 414.635, 414.651 & ORS 413.042

Statutes/Other Implemented: ORS 414.610–414.685

History:

DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3870 Intensive Care Coordination (Proposed Changes Effective 1/1/21)**

(1) CCOs are responsible for Intensive Care Coordination (ICC) services. The requirements described in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 and 410-141-3865.

(2) "Prioritized Populations" means individuals who:

(a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;

(b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);

(c) Are children ages 0-5 ~~showing;~~

(i) Showing early signs of social/emotional or behavioral problems or ~~;~~

(ii) H~~h~~ave a Serious Emotional Disorder (SED) diagnosis;

(d) Are in medication assisted treatment for SUD;

(e) Are women who have been diagnosed with a high-risk pregnancy;

(f) Are children with neonatal abstinence syndrome;

(g) Children in Child Welfare;

(h~~f~~) Are IV drug users, have SUD in need of withdrawal management;

(i~~g~~) Have HIV/AIDS or have tuberculosis;

(j~~h~~) Are veterans and their families; and

(k~~i~~) Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

(3) "Intensive Care Coordinator" (ICC Care Coordinator) means a person coordinating ICC services as defined in this rule.

(4) "Intensive Care Coordination Plan" (ICC Plan) means a collaborative, comprehensive, integrated and interdisciplinary-focused written document that includes details of the supports, desired outcomes,

activities, and resources required for an individual receiving ICC Services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.

(5) All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children who are members of a prioritized population shall be provided behavioral health services according to presenting needs.

(6) CCOs shall also conduct an ICC assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below in this section (6). All referrals for ICC assessments shall be responded to by the CCO within one business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening. ICC assessments shall be conducted when:

(a) A health risk screening conducted under, and in accordance with, OAR 410-141-3865 indicates a member has special health care needs or other needs or conditions that may indicate a need for ICC services;

(b) A member refers themselves;

(c) A member's representative or provider, including a home and community- based services provider, refers the member; or

(d) Upon referral of any medical personnel serving as a member's LTCSS case manager.

(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC needs. CCOs shall have established process for responding to all requests for ICC assessments or services, which shall include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one business day.

(8) ICC assessments shall identify the physical, behavioral, oral and social needs of a member.

(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (c)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility revise care plans, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:

(a) For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865 and this rule. Contract shall be made with the member by the ICC care coordinator within three calendar days of receipt of notice of a reassessment triggering event;

(b) Reassessment triggering events include all of the following events:

(A) New hospital visit (ER or admission);

(B) New high-risk pregnancy diagnosis;

(C) New chronic disease diagnosis (includes behavioral health);

(D) New behavioral health diagnosis;

(E) Opioid drug use;

(F) IV drug use;

(G) Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);

(H) New I/DD diagnosis;

(I) Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;

(J) Recent homelessness;

(K) Two or more billable primary Z code diagnoses within one month;

(L) Two or more caregiver placements within past six months;

(M) An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;

(N) Discovery of new or ongoing behavioral health needs;

(O) Discharge from a residential setting or long-term care back to the community;

(P) Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;

(Q) Two or more readmissions to an acute care psychiatric hospital in a 6-month period;

(R) Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period; and

(S) Exit from condition-specific program.

(c) Members shall be reassessed for ICC services and care plans or, if applicable, ICC plans shall be revised annually;

(d) Reassessment for ICC services and care plans, or if applicable, ICC plans, revised if necessary, must be performed upon member request.

(10) Members eligible for ICC shall be assigned an ICC care coordinator:

(a) ICC Care coordinator assignments must be made within three business days of determining a member is eligible for ICC services;

(b) If a member is in a condition-specific program at the time they are determined eligible for ICC services, or enters a condition-specific program while receiving ICC services, then the CCO will appoint

the care coordinator of the condition-specific program as the ICC care coordinator for the member while the member is in the condition-specific program. After a member transitions from a condition-specific program, the CCO must reassess the member for ICC services within seven calendar days of the transition and assign a new ICC care coordinator within three business days of the completion of the ICC reassessment;

(c) CCOs shall notify members of their ICC status by at least two means of communication within five business days following the completion of the ICC assessment. Notifications shall include details about the ICC program and the name and contact information of their assigned ICC care coordinator.

(11) CCOs shall implement procedures to share the results of ICC assessment including, without limitation, identifications made as a result of the assessment and intensive care coordination plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.679 and applicable state and federal privacy laws and meet timely access standards set forth in in 410-141-3515.

(12) ICC services shall include, without limitation:

(a) Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;

(b) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;

(c) Assistance to medical providers with coordination of capitated services and discharge planning; and

(d) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(13) ICC Care coordinators must provide the following services:

(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least once every three months and make other kinds of contact (face to face when possible) three times a month or more frequently if indicated. If an ICC care coordinator is unable to comply with the member contact requirements, the CCO must document attempts made, barriers, and remediation efforts taken to overcome the barriers to the member contact requirements;

(b) Contact the member no more than three calendar days after receiving notification of a reassessment trigger described in section (9) of this rule. If an ICC care coordinator is unable to make contact with the member within three calendar days of a reassessment trigger, the ICC care coordinator must document in the member's case file all efforts made to contact the member. ICC care coordinators must continue brief contacts with members who have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back to the routine contact requirements under subsection (a) of this section (13);

(c) Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care;

(d) Facilitate communication between and among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;

(e) Convene and facilitate interdisciplinary team meetings monthly, or more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's

participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7)(d). The ICC care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:

(A) Describe the clinical interventions recommended to the treatment team;

(B) Create a space for the member to provide feedback on their care, self-reported progress towards their ICC plan goals and their strengths exhibited in between current and prior meeting;

(C) Identify coordination gaps and strategies to improve care coordination with the member's service providers;

(D) Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and

(E) Align with the member's individual ICC plan.

(f) Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.

(14) If a member is enrolled in other programs, including condition-specific programs, where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager shall be responsible for supporting specific needs based on their specialty within the interdisciplinary team.

(15) CCOs shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. CCOs shall produce ICC plans for each member requiring ICC services. Each ICC plan shall:

(a) Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTSS providers and the member's participation;

(b) Include consultations with any specialist(s) caring for the member and Medicaid funded long-term services and supports providers and case managers or for full benefit dual eligible (FBDE) members, Medicare providers or MCE aligned Medicare Advantage or Dual Special Needs Plan care coordinators;

(c) Be approved by the CCO in a timely manner if CCO approval is required;

(d) In alignment with rules outlined in OAR 410-141-3835 CCO Service Authorization; and

(e) In accordance with any applicable quality assurance and utilization review standards.

(16) CCOs shall periodically inform all participating providers of the availability of ICC and other support services available for members. CCOs shall also periodically provide training for patient-centered primary care homes and other primary care provider staff.

(17) CCO staff providing or managing ICC care coordination services shall be required to:

(a) Be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the CCO's service areas who are identified as being of a prioritized population;

(b) If a Member is unable to receive services during normal business hours, the CCO shall provide alternative availability options for the member;

(c) Be trained for, and exhibit skills in, person-centered care planning and trauma informed care; and communication with and sensitivity to the special health care needs of priority populations. CCOs shall have a written position description for its staff responsible for managing ICC services and for staff who provide ICC services;

(d) CCOs shall have written policies that outline how the level of staffing dedicated to ICC is determined. The ICC policies must include, without limitation, care coordination staffing standards such that the complexity, scope, and intensity of the needs of members receiving ICC services can be met.

(18) Consistent with the requirements under this rule, CCOs shall make Integration and Care Coordination services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal

business hours, Monday through Friday. If a Member is unable to receive services outside of normal business hours, the CCO shall provide alternative availability options for member.

(19) CCOs shall have a process to provide members with special health care needs who are receiving ICC services or are receiving Medicaid-funded LTSS with direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs. CCOs shall have processes in place to ensure it reviews member needs for LTSS and mechanisms to identify and refer to the Department of human services, inclusive of its area agency on aging, office of developmental disabilities services, and aging and people with disability programs, or, as may be applicable to a 1915(i) provider for LTSS assessment and services.

Statutory/Other Authority: 413.042, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

**410-141-3875 MCE Grievances & Appeals: Definitions and General Requirements**

**(Proposed Changes Effective 1/1/21)**

(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) The denial, in whole or in part, of payment for a service;

(D) The failure to provide services in a timely manner pursuant to 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) "Contested Case Hearing" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;

(d) "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;

(e) "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;

(f) "Member." With respect to actions taken regarding grievances and appeals, references to a "member" include, 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;

(g) "Notice of Adverse Benefit Determination" means the notice must meet all requirements found at 42 CFR 438.4004.

(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 action/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 action/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) 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) 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) 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) 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) and these rules.

(5) Upon receipt of a grievance or appeal, the MCE shall:

(a) Within 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) 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 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 oral 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;

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

(d) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(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 the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing 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 413.032, 414.615, 414.625, 414.635 & 414.651

Statutes/Other Implemented: ORS 414.610 - 414.685

History:

DMAP 57-2019, adopt filed 12/17/2019, effective 01/01/2020

**410-141-3910 Grievances & Appeals: Continuation of Benefits (Proposed Changes Effective 1/1/21)**

(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 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 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.

(dc) ~~The benefits shall continue until~~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) ~~Unless the member requests a contested case hearing with continuing benefits, no later than 10 days following the date of the MCE notice of appeal resolution, a final appeal resolution resolves the MCE appea~~The member fails to request a hearing and continuation of benefits within 10 calendar days after the MCE sends the notice of appeal resolution~~.~~;

(B) The member withdraws the appeal or request for hearing~~A final order resolves the contested case~~;

~~(C) The time period or service limits of a previously authorized service have been met; or~~

(C~~D~~) A final order resolves the hearing~~The member withdraws the request for a 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 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;

(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

History:

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**410-141-3920 Transportation: NEMT General Requirements**
**(Proposed Changes Effective 1/1/21)**

(1) A CCO shall provide all non-emergency medical transportation (NEMT) services for its members. For purposes of OAR 410-141-3920 to 410-141-3965, references to a "member" include any individual eligible for NEMT services under this section (1) unless context dictates otherwise.

(2) A CCO shall provide a toll-free call center for members to request rides.

(3) Neither a CCO nor any of its Subcontracted transportation providers may bill a member for transport to or from covered medical services, even if the CCO or its contracted transportation provider denied reimbursement for the transportation services.

(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).

(5) A CCO shall have written policies and procedures regarding its NEMT services. The CCO's policies and procedures shall be included in the CCO's Member Handbook, posted on the CCO's website, and included in the CCO's other general information materials. The CCO may have a separate, stand-alone document that includes only its written policies and procedures regarding its NEMT service so long as the stand-alone document is provided to members at the same time and in the same manner that the member handbook is provided to members and so long as the stand-alone document complies with all of the same accessibility and other specifications required of the member handbook. The CCO's written policies and procedures regarding NEMT services shall provide, without limitation, for the following:

(a) Allow members or their representatives to schedule:

(A) NEMT services up to 90 days in advance;

(B) Multiple NEMT services at one time for recurring appointments up to 90 days in advance; and

(C) Same-day NEMT services.

(b) Comply with the following criteria for member drop-offs and pick-up protocols:

(A) Not permit drivers to drop Members off at an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the member or, as applicable, the Member's guardian, parent, or representative; and

(B) Not permit drivers to pick up Members from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the member, or as applicable, the Member's guardian, parent, or representative; and

(c) Describe passenger rights and responsibilities as set forth in 42 CFR §438.210, and as set forth in OARs 410-141-3920 through 410-141-3960, and other state and federal administrative statutes and rules relating to the rights and responsibilities of Medicaid recipients such as ~~including~~ the right to file a grievance and request an appeal or reconsideration.

(6) The grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 are available with respect to NEMT services, with the following modifications:

(a) Prior to mailing a notice of adverse benefit determination to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.

(b) The CCO shall mail, within 72 hours of denial, a notice of adverse benefit determination to:

(A) A member denied a ride; and

(B) The provider with which the affected member was scheduled for an appointment provided that the provider is part of the CCO's provider network and requested the transportation on the member's behalf.

Statutory/Other Authority: ORS 413.042 & 414.625
Statutes/Other Implemented: ORS 414.625