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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division: 410
Medical Assistance Programs

Agency and Division	Administrative Rules Chapter Number
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RULE CAPTION

Definition Addition of Managed Care Entity (MCE)
Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-0000

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.065

RULE SUMMARY

In order to find a singular term that could be used to represent all plan types in Medicaid rule language and in an effort to be compliant with the term, the Authority sought guidance from CMS with particular consideration given to the new managed care rules. The response received from CMS: To your question, Managed

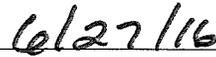
Care Entity (MCE) is a definition that can be used to encompass multiple organizations, plans, etc., (in your/Oregon's case CCO, DCO, MHO). Managed Care Entity is currently defined at 42 CFR 457.10: Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Link to 42 CFR 457.10: http://www.ecfr.gov/cgi-bin/text-idx?SID=c5cba4e2e28a4c186d3c4a075f239285&mc=true&node=se42.4.457_110&rgn=div8. It is the Authority's intent to use the term 'managed care entity (MCE)' starting with OAR 410-141-0000 to house the definition referenced above. There have also been two cross references directing the reader to OAR 410-120-0000 added for the terms 'client' and 'member.'



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410-141-0000

Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply:

(1) “Action” means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(a) The denial or limited authorization of a requested service including the type or level of service;

(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 as defined by the Health Systems Division, Medical Assistance Programs (Division);

(e) The failure of a PHP or CCO to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:

(A) From any other provider (in terms of training, experience, and specialization) not available within the network;

(B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;

(C) Because the only plan or provider available does not provide the service due to moral or religious objections;

(D) Because the member’s provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or

(E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.

(2) “Adjudication” means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final CCO or MCO claims decision or the Authority issuing a final

hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

(3) “Capitated Services” means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.

(4) “Capitation Payment” means monthly prepayment to a PHP for health services the PHP provides to members.

(5) “CCO Payment” means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.

(6) “Certificate of Authority” means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(7) “Client” has the meaning given that term in OAR 410-120-0000.

(8) “Cold Call Marketing” means a PCP’s or CCO’s unsolicited personal contact with a potential member for the purpose of marketing.

(9) “Community Advisory Council” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.

(10) “Community Standard” means typical expectations for access to the health care delivery system in the member’s community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs take into consideration the community standard and be adequate to meet the needs of the Division.

(11) “Contract” means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.

(12) “Converting MCO” means a CCO that:

(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;

(b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.

(13) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

(14) “Coordinated Care Services” mean a CCO’s fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(15) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(16) “Dental Care Organization (DCO)” means a PHP that provides and coordinates dental services as capitated services under OHP.

(17) “Dental Case Management Services” means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(18) “DCBS Reporting CCO” means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(19) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection agency.

(20) “Disenrollment” means the act of removing a member from enrollment with a PHP or CCO.

(21) “Exceptional Needs Care Coordination (ENCC)” means for PHPs a specialized case management service provided by FCHPs to members identified as aged, blind, or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those members who are aged, blind, or disabled who have complex medical needs;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

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

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(22) “Enrollment” means the assignment of a member to a PHP or CCO for management and receipt of health services.

(23) “Free-Standing Mental Health Organization (MHO)” means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.

(24) “Fully-Capitated Health Plan (FCHP)” means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.

(25) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(26) “Grievance” means a member’s complaint to a PHP, CCO, or to a participating provider about any matter other than an action.

(27) “Grievance System” means the overall system that includes:

(a) Grievances to a PHP or CCO on matters other than actions;

(b) Appeals to a PHP or CCO on actions; and

(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or state statute.

(28) “Health Services” means:

(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;

(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

(29) “Holistic Care” means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.

(30) “Home CCO” means enrollment in a CCO in a given service area based upon a client’s most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization.

(31) “Intensive Case Management (ICM)” means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including:

- (a) Early identification of members eligible for ICM services;
- (b) Assistance to ensure timely access to providers and capitated services;
- (c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;
- (d) Assistance to providers with coordination of capitated services and discharge planning; and
- (e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(32) “Licensed Health Entity” means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(33) “Line Items” means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

(34) “Managed care entity (MCE)” means, as stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers.

(35) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(36) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(37) “Member” has the meaning given that term in OAR 410-120-0000.

(38) “Mental Health Organization (MHO)” means a PHP that provides capitated behavioral services for clients.

(39) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(40) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

(41) “Non-Participating Provider” means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.

(42) “Oregon Health Authority or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.

(43) “Other Non-Medical Services” means non-state plan, health related services, also referred to as “flexible services.” These services are provided in-lieu of traditional benefits and are intended to improve care delivery, member health, and lower costs. Services may effectively treat or prevent physical or behavioral healthcare conditions. Services are consistent with the member’s treatment plan as developed by the member’s primary care team and documented in the member’s medical record.

(44) “Participating Provider” means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.

(45) “Physician Care Organization (PCO)” means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.

(46) “Potential Member” means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.

(47) “Prioritized List of Health Services” means the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.

(48) “Service Area” means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(49) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy is designed in collaboration with the member, the member’s family, or the member representative and may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.

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