

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Add Dental Care Organization language (DCO) language for dental integration into CCO's	
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)	

In the Matter of: The proposed amendment of OAR 410-141-3060, 410-141-3080, 410-141-3220 and 410-141-3420

Statutory Authority: ORS 414.032, 414.615, 414.625, 414.635 and 414.651

Other Authority:

Stats. Implemented: ORS 414.610 through 414.685

Need for the Rule(s):

The Division needs to amend these rules to incorporate language related to dental services being integrated into the Coordinated Care Organizations (CCO). Changes have been made for clarity of rule language; the addition of effective dates, behavioral health and Dental Care Organization.

This rule revision is needed immediately to assist the CCOs who will be integrating dental services into their CCOs and for DCOs who will be affiliated with a CCO but still responsible for oral care for clients.

The Division is amending these rules to comply with legislative requirements and allow clients to enroll in or disenroll from a CCO or DCO as a "client choice" option based on integrated or affiliated care organizations available in the clients service area, and to clarify the eligibility groups exempt from enrollment and allow CCOs and DCOs to work together to coordinate a client's physical health and oral health care needs.

Documents Relied Upon, and where they are available: HB 3650  
<http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.en.pdf>

Fiscal and Economic Impact: See below

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

The Division does not anticipate fiscal impacts on other state agencies, units of local government or the public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

The types of small businesses include doctor's offices, specialty groups, small clinics and community based providers, however, the Division's system does not flag which providers are part of a larger clinic or corporation, therefore the Division is unable to estimate the number of small businesses that are subject to the rules but the Division does not anticipate a direct or indirect impact on small businesses.

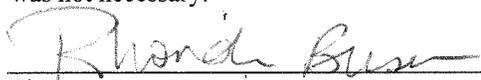
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None anticipated

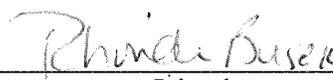
c. Equipment, supplies, labor and increased administration required for compliance: None anticipated

How were small businesses involved in the development of this rule? N/A

Administrative Rule Advisory Committee consulted?: No

If not, why?: As these rule changes are not substantive policy changes, it was determined that a Rule Advisory Committee was not necessary.

  
Signature

  
Printed name

7-3-13  
Date

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING\***  
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410  
Agency and Division Administrative Rules Chapter Number

Cheryl Peters 500 Summer St NE, Salem, OR 97301 DMAP.Rules@dhsosha.state.or.us 503-945-6527  
Rules Coordinator Address Telephone

*Dental* *7/17/13*  
Add ~~Coordinated~~ *DCO* Care Organization language *for dental integration* **RULE CAPTION** *language for dental integration into CCO's*  
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

8/16/2013 10:30 500 Summer St NE, Salem, OR 97301, Room 137C Cheryl Peters,  
Hearing Date Time Location Hearings Officer  
*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

**ADOPT:**

**AMEND:** OAR 410-141-3060, 410-141-3080, 410-141-3220 and 410-141-3420

**REPEAL:**

Stat. Auth. : ORS 414.032, 414.615, 414.625, 414.635 and 414.651

Other Auth.: None

Stats. Implemented: ORS ORS 414.610 through 414.685

**RULE SUMMARY**

The Division needs to amend these rules to incorporate language related to dental services being integrated into the Coordinated Care Organizations (CCO). Changes have been made for clarity of rule language; the addition of effective dates, behavioral health and Dental Care Organization.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

8/19/2013 by 5:00 p.m.

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

*Phunch Busek* *Phunch Busek* *7-3-13*  
Signature Printed name Date

\*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

## 410-141-3060

### Enrollment Requirements in a CCO

- (1) A client who is eligible for or receiving health services must enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and 414.632(2) or exempted by this rule.
- (2) If, upon application or redetermination, a client does not select a CCO, the Authority shall enroll the client and the client's household in a CCO that has adequate health care access and capacity.
- (3) For existing members of a PHP that has transitioned to a CCO, the Authority shall enroll those members in the CCO when the Authority certifies and contracts with the CCO. The Authority shall provide notice to the enrollees 30 days before the effective date.
- (4) Existing members of a PHP that is on the path to becoming a CCO shall retain those members. The Authority shall enroll those members in the CCO when certification and contracting are complete. The Authority shall provide notice to the clients 30 days before the effective date.
- (5) Unless otherwise exempted by sections (17) and (18) of this rule, existing clients receiving their physical health care services on a fee-for-service basis shall enroll in a CCO serving their area that has adequate health care access and capacity. They must enroll by November 1, 2012. The Authority shall send a notice to the clients 30 days before the effective date.
- (6) The following apply to clients receiving physical health care services on a fee-for-service basis but managed or coordinated behavioral health services ~~in a MHO~~:
  - (a) The Authority shall enroll the client in a CCO that is serving the client's area before November 1, 2012;
  - (b) The client shall receive their behavioral health care services from that CCO;
  - (c) The client shall continue to receive their physical health care services on a fee-for-service basis; and
  - (d) On or after November 1, 2012, the Authority shall enroll the client in a CCO for both physical health and behavioral health care services, unless otherwise exempted by sections (17) and (18) of this rule.

(e) On or after November 1, 2012, for the client exempt from coordinated physical health services by sections (17) and (18) shall receive managed or coordinated behavioral health services from a CCO, or MHO.

(7) The following apply to clients enrolled in Medicare:

(a) A client may enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(b) A client enrolled in Medicare Advantage, whether or not they pay their own premium, may enroll in a CCO, even if the CCO does not have a corresponding Medicare Advantage plan.

(c) A client may enroll with a CCO, even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(d) A client may enroll with a CCO, even if the client is enrolled in Medicare Advantage with another entity.

(8) From August 1, 2012, until November 1, 2012, enrollment is required in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. The following outlines the priority of enrollment during this period in service areas where enrollment is required:

(a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client must enroll in a PHP if:

(A) A PHP serves an area that a CCO does not serve; or

(B) A PHP serves an area that a CCO serves, but the CCO has inadequate health care access and capacity to accept new members;

(c) Priority 3: The client shall receive services on a fee-for-service basis.

(9) From August 1, 2012, until November 1, 2012, enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP. If a client decides to enroll in a CCO or PHP, the priority of enrollment in section (8) applies.

(10) On or after November 1, 2012, CCO enrollment is required in all areas. The following outlines the priority of options to enroll in all service areas:

- (a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;
- (b) Priority 2: The client must enroll in a PHP on the path to becoming a CCO if:
- (A) The PHP serves an area that a CCO does not serve; or
  - (B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members;
- (c) Priority 3: The client must enroll in a PHP that is not on the path to becoming a CCO if:
- (A) The PHP serves an area that a CCO does not serve; or
  - (B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care access or capacity to accept new members;
- (d) Priority 4: The client shall receive physical services on a fee-for-service basis.
- (11) On or after July 1, 2013, a client must enroll in a CCO or managed dental care organization (DCO) in a service area where a CCO or DCO has adequate dental care access and capacity, and a CCO or DCO is open to enrollment.
- ~~(12) A client may enroll in a DCO in a service area where a DCO has inadequate dental care access and capacity. In these service areas, a client may:~~
- ~~(a) Select any DCO open for enrollment; or~~
  - ~~(b) Obtain dental services on a FFS basis.~~
- (13) If a client receives physical health care through a PHP, PCM or on a fee-for-service basis, under circumstances allowed by this rule, the client must enroll in a CCO or mental (behavioral) health organization (MHO) in a service area where MHO enrollment is required. The following determines if a service area requires CCO or MHO enrollment:
- (a) CCO: The service area has adequate CCO behavioral health care access and capacity;
  - (b) MHO: A CCO does not serve in the area; or
  - (c) MHO: A CCO serves the area, but the CCO has inadequate health care access and capacity to accept new members:
- (124) From August 1, 2012, until November 1, 2012, if a service area changes from required enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or

Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-41-3080.

(1~~35~~) At the time of application or recertification, the primary person in the household shall select the CCO on behalf of all household members on the same household case. If the client is not able to choose a CCO, the client's representative shall make the selection.

(1~~46~~) The Department or OYA shall select the CCO for a child in the legal custody of the Department or OYA, except for children in subsidized adoptions.

(1~~57~~) The following populations are exempt from CCO enrollment:

(a) Populations expressly exempted by ORS 414.631(2) (a), (b) and (c), which includes:

(A) Persons who are non-citizens who are eligible for labor and delivery services and emergency treatment services;

(B) Persons who are American Indian and Alaskan Native beneficiaries; and

(C) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(b) Newly eligible clients are exempt from enrollment with a CCO if the client became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service basis only until the hospital discharges the client. The client is not exempt from enrollment in a DCO. The client is not exempt from enrollment in a DCO.

(c) Children in the legal custody of the Department or OYA where the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) Access to health care on a fee-for-service basis is not available; or

(B) Enrollment would preserve continuity of care.

(d) Clients with major medical health insurance coverage, also known as third party liability, except as provided in OAR 410-141-3050;

(e) Clients receiving prenatal services through the Citizen/Alien Waivered-Emergency Medical program; and

(f) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs.

(168) The following populations are exempt from CCO enrollment until specified below:

(a) From August 1, 2012, until November 1, 2012, children under 19 years of age who are medically fragile and who have special health care needs. Beginning November 1, 2012, the Authority may enroll these children in CCOs on a case-by-case basis; children not enrolled in a CCO shall continue to receive services on a FFS basis.

(b) Women who are in their third trimester of pregnancy when first determined eligible for OHP or at re-determination may qualify as identified below to receive OHP benefits on a Fee-for-Service (FFS) basis until 60 days after the birth of her child. After the 60 day period the OHP member must enroll in a CCO. In order to qualify for the FFS third trimester exemption the member must:

(A) Not have been enrolled with a service area CCO, FCHP or PCO during the three months preceding re-determination,

(B) Have an established relationship with a licensed qualified practitioner who is not a participating provider with the service area CCO, FCHP or PCO and wishes to continue obtaining maternity services from the non-participating provider on a FFS basis, and

(C) Make a request to change to FFS prior to the date of the delivery if enrolled with a CCO, FCHP or PCO.

(c) From August 1, 2012 until November 1, 2012, clients receiving health care services through the Breast and Cervical Cancer Program are exempt. Beginning November 1, 2012, enrollment is required;

(d) Existing clients who had organ transplants are exempt until the Authority enrolls them in a CCO on a case-by-case basis; and

(e) From August 1, 2012, until November 1, 2012, clients with end-stage renal disease. Beginning November 1, 2012, enrollment is required.

(179) The following clients who are exempt from CCO enrollment and who receive services on a fee-for-service basis may enroll in a CCO:

(a) Clients who are eligible for both Medicare and Medicaid;

(b) Clients who are American Indian and Alaskan Native beneficiaries;

| (1820) The Authority may exempt clients or temporarily exempt clients for other just causes as determined by the Authority through **medical review**. The Authority may set an exemption period on a case-by-case basis. Other just causes include the considerations:

- (a) Enrollment would pose a serious health risk; and
- (b) The Authority finds no reasonable alternatives.

| (1924) The following pertains to the effective date of the enrollment. If the enrollment occurs:

- (a) On or before Wednesday, the date of enrollment shall be the following Monday; or
- (b) After Wednesday, the date of enrollment shall be one week from the following Monday.

| (202) Coordinated care services shall begin on the first day of enrollment with the CCO except for:

- (a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;
- (b) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;
- (c) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, 414.651  
Stats. Implemented: ORS 414.610 – 685

## 410-141-3080

### Disenrollment from Coordinated Care Organizations

This rule applies to DCO's and non-integrated CCO's. A non-integrated CCO is a CCO that has not integrated dental services.

(1) At the time of recertification, a ~~member~~client may disenroll from ~~a~~one CCO or DCO in a service area and enroll in another CCO or DCO in that service area. The primary person in the household shall make this decision on behalf of all household members.

(2) A member who moves from one service area to another service area shall disenroll from the CCO or DCO in the previous service area and enroll with a CCO or DCO in the new service area. The member must change their address with the Authority or Department within ten days of moving.

(3) A member who previously had an exemption from managed care physical health but is enrolled in a MHO or DCO may disenroll from the MHO or DCO to enroll into an integrated CCO in their service area.

~~(4)~~ A member who voluntarily enrolls in a CCO or DCO per OAR 410-141-3060 (19) may disenroll from their CCOs or DCO's at any time and receive health care services on a fee-for service basis or enroll in another CCO or DCO in their service area. This only applies to:

(a) Members who are eligible for both Medicare and Medicaid and

(b) Members who are American Indian and Alaskan Native beneficiaries;

(c) (4) Notwithstanding other sections of this rule, members may request disenrollment for just cause at any time pursuant to state law or CFR 438.56. This includes:

(a) The CCO or DCO does not cover the service the member seeks, because of moral or religious objections;

(b) The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(c) The member is experiencing poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

(5) The Authority may approve the disenrollment after medical review using the following just cause considerations:

(a) Required enrollment would pose a serious health risk; and

(b) The Authority finds no reasonable alternatives.

(6) The following applies to time lines for clients to change their CCO or DCO assignment:

(a) Newly eligible clients may change their CCO or DCO assignment within 90 days of their application for health services;

(b) Existing ~~members~~clients may change their CCO or DCO assignment within 30 days of the Authority's automatic assignment in a CCO or DCO; or

(c) ~~Members~~Clients may change their CCO or DCO assignment upon eligibility redetermination.

- (d) Members~~Clients~~ may change enrollment in their CCO or DCO once during each enrollment period.
- (7) Pursuant to CFR 438.56, the CCO or DCO shall not request and the Authority shall not approve disenrollment of a member due to:
  - (a) A physical or behavioral disability or condition;
  - (b) An adverse change in the member's health;
  - (c) The member's utilization of services, either excessive or lacking;
  - (d) The member's decisions regarding medical or dental care with which the CCO or DCO disagrees;
  - (e) The member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, resulting from the member's special needs, except when continued enrollment in the CCO or DCO seriously impairs the CCO's or DCO's ability to furnish services to this particular member or other members.
- (8) A CCO or DCO may request the Authority to disenroll a member if the CCO or DCO determines:
  - (a) Except as provided in OAR 410-141-3050, the member has major medical coverage, including employer sponsored insurance (ESI) ~~but excluding enrollment in a DCO~~;
  - (b) The CCO or DCO determines:
    - (A) The member has moved to a service area the CCO or DCO does not serve;
    - (B) The member is out of the CCO's or DCO's area for three months without making arrangements with the CCO or DCO;
    - (C) The member did not initiate enrollment in the CCO or DCO serving the member's area; and
    - (D) The member is not in temporary placement or receiving out-of-area services.
  - (c) The member is in a state psychiatric institution;
  - (d) The CCO or DCO has verifiable information that the member has moved to another Medicaid jurisdiction; or
  - (e) The member is deceased.
- (9) Before requesting disenrollment under the exception in section (7)(e) of this rule, a CCO or DCO must take meaningful steps to address the member's behavior, including but not limited to:
  - (a) Contacting the member either orally or in writing to explain and attempt to resolve the issue. The CCO or DCO must document all oral conversations in writing and send a written summary to the member. This contact may include communication from advocates, including peer wellness specialists, where appropriate, personal health navigators and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
  - (b) Developing and implementing a care plan in coordination with the member and the member's care team that details the problem and how the CCO or DCO shall address it;
  - (c) Reasonably modifying practices and procedures as appropriate to accommodate the member's circumstances;
  - (d) Assessing the member's behavior to determine if it results from the member's special needs or a disability;
  - (e) Providing education, counseling and other interventions to resolve the issue; and

(f) Submitting a complete summary to the Authority if the CCO or DCO requests disenrollment.

(10) The Authority may disenroll members of CCOs or DCOs for the reasons specified in Section (8) without receiving a disenrollment request from a CCO or DCO.

(11) The CCO or DCO shall request the Authority to suspend a member's enrollment when the inmate is incarcerated in a State or Federal prison, a jail, detention facility or other penal institution for no longer than 12 months. The CCO or DCO shall request that the Authority disenroll a member when the inmate is incarcerated in a State or Federal prison, jail, detention facility or other institution for longer than 12 months. This does not include members on probation, house arrest, living voluntarily in a facility after adjudication of their case, infants living with inmates or inmates admitted for inpatient hospitalization. The CCO or DCO is responsible for identifying the members and providing sufficient proof of incarceration to the Authority for review of the request for suspension of enrollment or disenrollment. CCOs shall pay for inpatient services only during the time a member is an inmate and enrollment is otherwise suspended.

(12) Unless otherwise specified in these rules or in the Authority notification of disenrollment to the CCO or DCO, all disenrollments are effective at the end of the month the Authority approves the disenrollment, with the following exceptions;

(a) The Authority may specify a retroactive disenrollment effective date if the member has:

(A) Third party coverage including employee-sponsored insurance. The effective date shall be the date the coverage begins;

(B) Enrolls in a program for all-inclusive care for the elderly (PACE). The effective date shall be the day before PACE enrollment;

(C) Is admitted to the State Hospital. The effective date shall be the day before hospital admission; or

(D) Becomes deceased. The effective date shall be the date of death.

(b) The Authority may retroactively disenroll or suspend enrollment if the member is incarcerated pursuant to section (11) of this rule. The effective date shall be the date of the notice of incarceration or the day before incarceration, whichever is earlier.

(c) The Authority shall specify a disenrollment effective date if the member moves out of the CCO's or DCO's service area. The Authority shall recoup the balance of that month's capitation payment from the CCO or DCO;

(d) The Authority may specify the disenrollment effective date if the member is no longer eligible for OHP;

(13) The Authority shall inform the members of a disenrollment decision in writing, including the right to request a contested case hearing to dispute the Authority's disenrollment if the Authority disenrolled the member for cause that the member did not request. If the member requests a hearing, the disenrollment shall remain in effect pending outcome of the contested case hearing.

(14) For purposes of a member's right to a contested case hearing, "disenrollment" does not include the Authority's:

(a) Transfer of a member from a PHP to a CCO or DCO;

(b) Transfer of a member from a CCO or DCO to another CCO or DCO; or

(c) Automatic enrollment of a member in a CCO or DCO.

(15) The Authority may approve the transfer of 500 or more members from one CCO [or DCO](#) -to another CCO [or DCO](#) if:

(a) The members' provider has contracted with the receiving CCO [or DCO](#) and has stopped accepting patients from or has terminated providing services to members in the transferring CCO [or DCO](#); and

(b) Members are offered the choice of remaining enrolled in the transferring CCO [or DCO](#).

(16) Members may not be transferred under section (15) until the Authority has evaluated the receiving CCO [or DCO](#) and determined that the CCO [or DCO](#) meets criteria established by the Authority by rule, including but not limited to ensuring that the CCO [or DCO](#) maintains a network of providers sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(17) The Authority shall provide notice of a transfer under section (15) to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(18) Except as otherwise allowed by rule, a member may transfer from one CCO [or DCO](#) to another CCO [or DCO](#) no more than once during each enrollment period.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685

#### **410-141-3220 Accessibility**

(1) Consistent with the community health assessment and health improvement plan, CCOs must assure that members have access to high quality care. The CCO shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The CCO shall develop and implement the assessment and plan over time that meets access-to-care standards, and allows for appropriate choice for members.

The goal shall be that services and supports should be geographically 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.

(2) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the CCO should anticipate access needs, so that the members receive the right care at the right time and place, using a patient-centered approach. The CCO provider network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.

(4) CCOs shall have policies and procedures which ensure that for 90% of their members in each service area, routine travel time or distance to the location of the PCPCH or PCP does not exceed the community standard for accessing health care participating providers. The travel time or distance to PCPCHs or PCPs shall not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas — 30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas — 60 miles, 60 minutes or the community standard, whichever is greater.

(5) CCOs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) CCOs shall make the services it provides including: primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services, as accessible to members for timeliness, amount, duration, and scope as those services are to other members within the same service area. If the CCO is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. CCOs shall have a monitoring system that shall demonstrate to the Authority that the CCO has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) CCOs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a

member shows evidence of behavioral health issues or when a member over utilizes services;

(b) CCOs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members.

(7) CCOs 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, behavioral health issues or who are children receiving Department or OYA services have access to primary care, dental care (when the CCO or DCO is responsible for dental care), mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.

(8) 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 as within the following timeframes:

(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, in accordance with OAR 410- 141-0140;

(c) Well care — Within 4 weeks or within the community standard;

(d) Emergency dental care (when dental care is provided by the CCO or DCO) — Seen or treated within 24- hours;

(e) Urgent dental care (when dental care is provided by the CCO or DCO) — Within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(f) Routine dental care (when dental care is provided by the CCO or DCO) — Seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;

(g) Non-Urgent behavioral health treatment — Seen for an intake assessment within 2 weeks from date of request.

(9) CCOs shall develop policies and procedures for communicating with, and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in CCO administrative offices, especially those of member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;

(b) CCOs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health or dental care (when the CCO or DCO is responsible for dental care) visits, and home health visits, to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint; to make a

diagnosis; respond to member's questions and concerns; and to communicate instructions to the member;

(c) CCOs shall ensure the provision of coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;

(d) CCOs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non- participating referral providers when necessary;

(e) CCOs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685

## **410-141-3420 Billing and Payment**

(1) Subject to other applicable Division billing rules, providers must submit all billings for CCO members following the timeframes in (a) and (b) below:

(a) Submit billings within 12 months of the date of service in the following cases:

(A) Member pregnancy;

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

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

(D) Other cases that could have delayed the initial billing to the CCO (which does not include failure of provider to certify the member's eligibility); or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 36.61, 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 payer of last resort and is not considered an alternative liability or TPL.

(b) Submit bills within four months of the date of service for all other cases.

(2) Providers must be enrolled with the Authority's Division of Medical Assistance Programs to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), must be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) Division before enrollment with the Authority or to be eligible for CCO payment for services. Providers may be retroactively enrolled, in accordance with OAR 410- 120-1260 (Provider Enrollment).

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

(4) Providers shall verify, before providing services, that the member is eligible for coordinated care services on the date of service. Providers shall use the Authority tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorization from the appropriate payer before providing services.

For non-covered services, providers shall follow requirements in OAR 141-120-1280.

(5) CCOs shall pay for all covered coordinated care services. These services must be billed directly to the CCO, unless the CCO or the Authority specifies otherwise. CCOs may require providers to obtain preauthorization to deliver certain coordinated care services.

(6) Payment by the CCO to participating providers for coordinated care services is a matter between the CCO and the participating provider, except as follows:

(a) CCOs shall have procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:

(A) Date stamping pre-authorization requests when received;

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

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

(D) The specific number of days following receipt of the additional information that a redetermination must be made;

(E) Providing services after office hours and on weekends that require preauthorization;

(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) CCOs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; ~~alcohol and drug~~ Substance Use Disorder services; or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO must provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within 2 working days of receipt of the request;

(c) For expedited prior authorization requests in which the provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The CCO may extend the three working day time period no more than 14 calendar days if the member requests an extension, or if the CCO justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(d) For all other preauthorization requests, CCOs shall notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request. CCOs must make reasonable efforts to obtain the necessary information during the 14-day period. However, the CCO may use an additional 14 days to obtain follow-up information, if the CCO justifies (to the Authority upon request) the need for additional information and how the delay is in the interest of the member. The CCO shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

(7) CCOs shall have written procedures for processing payment claims submitted from any source. The procedures shall specify time frames 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 of pended claims to obtain additional information;

(d) The specific number of days following receipt of additional information that a determination must be made; and

(e) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim;

(f) CCOs shall pay or deny at least 90% of valid claims within 45 calendar days of receipt and at least 99% of valid claims within 60 calendar days of receipt. CCOs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(g) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services, for which the member may be financially responsible. The CCO shall provide the notice to the member and the treating provider within 14 calendar days of the final determination. The notice to the member shall be a Division or AMH approved notice format and shall include information on the CCOs internal appeals process, and Hearing Rights (DMAP 3030) shall be attached. The notice to the provider shall include the reason for the denial;

(h) CCOs may not require providers to delay billing to the CCO;

(i) CCOs 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;

(j) CCOs 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;

(k) CCOs may not delay or deny payments because a co-payment was not collected at the time of service.

(8) CCOs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO, for authorized referral care, and urgent care services or emergency services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) CCOs shall pay transportation, meals and lodging costs for the member and any required attendant for out-of-state services that the CCO has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) CCOs shall pay for covered services provided by a non-participating provider which was not preauthorized if the following conditions exist:

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

(b) The covered service was delivered in good faith without the pre-authorization; and

(c) It was a covered service that would have been pre-authorized with a participating provider if the CCO's referral procedures had been followed;

(d) The CCO shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the CCO) for covered services that are subject to reimbursement from the CCO, in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals;

(e) CCOs 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 which 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 as referenced in ORS 442.470. CCO shall attest annually to the Authority, in a manner to be prescribed, to CCO's compliance with these requirements.

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

(a) Certain services must be authorized by the CCO 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 must verify a member's eligibility using the web portal or AVR;

(b) Services authorized by the CCO or CMHP are subject to the rules and limitations of the appropriate Authority 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 rules and limitations described in the relevant rules, contracts, billing instructions;

(e) The Authority may not pay a provider for provision of services for which a CCO has received a CCO 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 a CCO except as provided in Authority administrative rules and supplemental information (e.g., coordinated care services that are not included in the nursing facility all-inclusive rate);

(g) CCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the CCO would pay for the same service furnished by a provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(12) Coverage of services through the Oregon Health Plan Benefit Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

(13) Billing and coverage of Dental Services is governed by OAR 410 division 123.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685