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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance
Programs

410

Agency and Division

Administrative Rules Chapter Number

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Adopted on

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RULE CAPTION

Amend CCO Enrollment and Disenrollment Rules Aligning Current Practices and
Pregnancy Enrollment Exemption Processes

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-3060, 410-141-3080

SUSPEND:

Stat. Auth.: ORS 413.032, 413.042, 414.615, 414.625, 414.635 and 414.651

Other Auth.:

Stats. Implemented: ORS 414.610 - 414.685

RULE SUMMARY

The Division is amending OAR 410-141-3060 and 410-141-3080 to align these CCO rules reflecting current enrollment and disenrollment practices and to update them as they relate to the most recent pregnancy enrollment exemption protocols supporting OAR 410-130-0240, which provides the authority to withhold payment for out-of-hospital birth services if the pregnancy was not a low risk-http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_130.html.

STATEMENT OF NEED AND JUSTIFICATION

The amendment of OAR 410-141-3060 and 410-141-3080

In the Matter of

- The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup provided recommendations related to perinatal service options for Medicaid enrollees. OHA Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating the Division would implement changes necessitating the removal of the sunset date and allowing for time to make further program implementations and additional rule revisions.

- Minutes from the May 27, 2014 Medical Management Committee meeting. Minutes are available through the Division.

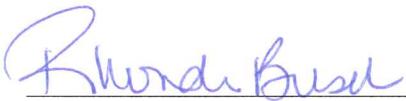
Documents Relied Upon, and where they are available

The Division needs to amend these CCO rules to reflect current enrollment and disenrollment practices and update them as they relate to the most recent pregnancy exemption protocols supporting OAR 410-130-0240. These rules provide information on the exemption process for clients electing to have an out of hospital birth.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, to the interest of Division clients, the Division, and providers. The Division needs to act promptly to ensure the third trimester pregnancy enrollment exemption is included in OAR 410-141-3060 and OAR 410-141-3080 to correctly reflect the appropriate and most current changes.

Justification of Temporary Rules



Authorized Signer



Printed Name



Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Medical Assistance Programs (MAP)

410

Agency and Division

Administrative Rules Chapter Number

Amend CCO Enrollment and Disenrollment Rules Aligning Current Practices and Pregnancy Enrollment Exemption Processes

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-141-3060 and 410-141-3080

Statutory Authority: ORS 413.032, 413.042, 414.615, 414.625, 414.635 and 414.651

Other Authority:

Stats. Implemented: ORS 414.610 – 414.685

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Documents Relied Upon, and where they are available:

- The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup provided recommendations related to perinatal service options for Medicaid enrollees. OHA Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating the Division would implement changes necessitating the removal of the sunset date and allowing for time to make further program implementations and additional rule revisions.
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Justification of Temporary Rule(s): The Authority finds that failure to act promptly will result in serious prejudice to the public interest, to the interest of Division clients, the Division, and providers. The Division needs to act promptly to ensure the *third trimester pregnancy enrollment exemption* is included in OAR 410-141-3060 and OAR 410-141-3080 to correctly reflect the appropriate and most current changes.



Authorized Signer



Rhonda Busek



Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

410-141-3060

Enrollment Requirements in a CCO

(1) For the purposes of this rule, the following definitions apply:

(a) “Client” means an individual found eligible to receive OHP health services. “Client” is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) “Eligibility Determination” means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) “Member” means a client enrolled with a pre-paid health plan or a coordinated care organization as stated in OAR 410-120-0000;

(d) “Newly Eligible” means recently determined, through the eligibility determination process, as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) “Redetermination” means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;

(f) “Renewal” means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) Pursuant to ORS 414.631, the following populations may not be enrolled into a CCO for any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

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

(3) The following populations may not be enrolled into a CCO under the following circumstances:

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

the hospital discharges the client. The individual ~~will~~shall receive dental services through the DCO;

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavioral Rehabilitation Services (BRS) and PRTS programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt mandatory enrollment into a managed care plan, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health CCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These populations are as follows:

(a) Children in the legal custody of the Department or 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 FFS basis is not available; or

(B) Enrollment would preserve continuity of care;

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these:

(A) A client has the option to 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, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;

(C) A client has the option to 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 has the option to enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.

(6) The Authority may 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 for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. 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) Until December 31, 2017, women who are pregnant and meet the qualifications in sub-sections A through ~~E-F~~ below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage ~~will~~ shall continue to be enrolled in the appropriate ~~MCO or~~ CCO plan in their service area for dental and mental health coverage. After the 60-day ~~post-partum period~~ estimated date of delivery, the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in A through ~~E~~ E below. In order to qualify for the FFS pregnancy exemption for physical health only, there ~~must~~ shall be no ~~home birth~~ out of hospital birth option available to the client through her plan, and the client ~~must~~ shall:

(A) Be pregnant;

(B) State that her intention is to have an ~~home birth~~ out of hospital birth;

(C) Have an established relationship for the purpose of ~~home birth~~ an out of hospital birth with a licensed, qualified practitioner who is not a participating provider with the client's CCO; and

(D) Make a request to change to FFS. This request can be made ~~at any point no later than the twenty-fourth through the end of the twenty-seventh week in the of pregnancy;~~ at any point no later than the twenty-fourth through the end of the twenty-seventh week in the of pregnancy; and

(E) ~~Meet any OAR~~ Meet all administrative rules including, but not limited to, OAR 410-130-0240 and statutory requirements that define when a ~~home birth~~ an out of hospital birth is eligible for reimbursement by the Authority; ~~and~~

(F) Meet any of the requirements specified in OAR 333-076-0650, either upon initial evaluation or once the exemption is granted. ~~Should~~ If a woman becomes unable to meet the requirements, the exemption shall be withdrawn and the client ~~will~~ shall be subject to CCO enrollment requirements as stated in OAR 410-141-3060.

~~(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1) Table 1 either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn and the client will be subject to CCO enrollment requirements as stated in OAR 410-141-3060.~~

~~(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:~~

~~(I) Fetal presentation other than vertex, when known;~~

~~(II) Abnormal Bleeding;~~

~~(III) Low-lying placenta within 2 cm or less of cervical os;~~

~~(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and~~

~~(V) Current substance abuse that has the potential to adversely affect labor and the infant;~~

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area;

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services ~~must~~ shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.

(8) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP.

(9) Enrollment is mandatory in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. If upon application or redetermination, a client does not select a CCO, the Authority shall auto-assign the client and the client's household to a CCO that has adequate health care access and capacity. The following outlines the priority of enrollment in service areas where enrollment is mandatory and a PHP remains available for enrollment:

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

(b) Priority 2: The client has the option to enroll in a PHP through a manual process if:

(A) The client has an established relationship with a provider who is only contracted with the PHP; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members. Clients ~~will~~shall be FFS unless already established with a PHP's provider;

(c) Priority 3: The client shall receive services on an an FFS basis.

(10) If a service area changes from mandatory 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 410-141-3080.

(11) Clients who are exempt from physical health services or who are enrolled with a PHP for physical health services ~~will~~shall receive managed or coordinated mental health and oral health services as follows:

(a) The client shall be enrolled with a CCO if the CCO offers mental health and oral health services; or

(b) The client shall be enrolled with an MHO for mental health services and with a DCO for oral health services if the CCO does not offer those services; or

(c) The client shall be enrolled with a DCO for oral health services and remain FFS for mental health services if an MHO is not available; or

(d) The client shall remain FFS for both mental health and oral health services if an MHO or DCO is unavailable.

(12) 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.

(13) Coordinated care services shall begin as of the effective date 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 persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

(d) 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 - 414.685

410-141-3080

Disenrollment from Coordinated Care Organizations

(1) For purposes of this rule, continuity of care means the ability to sustain services necessary for a person's treatment. Continuity of care is a concern when a member is transferred from one service provider to another.

(21) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) or Dental Care Organization (DCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO or DCO, where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(23) In accordance with 42 CFR 438.56(c)(2), the Authority, CCO, or DCO shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Newly eligible members may change their CCO or DCO assignment within ~~42-90~~ 90 days ~~months~~ following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months thereafter;

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

(D) In accordance with ORS 414.645, members may disenroll from a CCO or DCO during their redetermination (enrollment period) or one additional time during their

enrollment period based on the member's choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

(B) Due to moral or religious objections, the CCO or DCO does not cover the service the member seeks;

(C) When 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

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the CCO or DCO's service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060 ~~or this rule~~ and/or is as defined in this rule. Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP member or a provider of a treatment, service, or supply, including, but not limited to, a decision of a provider to participate or decline to participate in a CCO or DCO;

(iv) As specified in ORS 414.647~~5~~, the Authority may approve the transfer of 500 or more members from one CCO or DCO to another CCO or DCO if:

(I) The member's 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

(II) Members are offered the choice of remaining enrolled in the transferring CCO or DCO; and

(III) The member and all family (case) members shall be transferred to the provider's new CCO or DCO; and

(IV) The transfer shall take effect when the provider's contract with their current CCO or DCO contractual relationship ends, or on a date approved by the Division; and

(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO or DCO and determined that the CCO or DCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO or DCO maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing.

(c) If the following conditions are met:

(A) As supported in 42 CFR 438.56(d) (2), clients at any point in the third trimester of pregnancy, separate from those clients requesting out of hospital births as referenced in OAR 410-141-3060, and those clients newly determined eligible for OHP, or those clients newly re-determined eligible for OHP and not enrolled in a CCO or DCO within the past three months;

(B) Members enrolled with a new CCO that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider;

(i) The request to change CCO or return to FFS is made no later than twenty-four weeks prior to the date of delivery;

(C) The enrollment exemption shall remain in place until 60 days post-estimated date of delivery, at which time the member shall select and be enrolled in the appropriate CCO plan in their service area.

~~(A) The applicant is in the third trimester of pregnancy and has just been determined eligible for OHP, or the OHP client has just been re-determined eligible and was not enrolled in a CCO or DCO within the past three months; and~~

~~(B) The new CCO or DCO the member is enrolled with does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider; and~~

~~(C) The request to change CCO or DCO or return to FFS is made prior to the date of delivery.~~

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

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

(B) Involuntary 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.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another CCO or DCO, unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060(4) or 410-141-0060(4), or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another CCO or DCO in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

(C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

(34) The CCO or DCO may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;

(c) Because of the member's utilization of services, either excessive or lack thereof;

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO or DCO disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(45) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO or DCO requests it for cause, which includes, but is not limited to, the following:

(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP, such as: permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO or DCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or <http://www.oregon.gov/DHS/aboutdhs/fraud/> as appropriate, consistent with 42 CFR 455.13;

(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060(4);

(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO or DCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;

(B) There shall be notification from the provider to the CCO or DCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO or DCO. Such notification shall be documented in the member's clinical record. The CCO or DCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The CCO or DCO shall contact the member either verbally or in writing, if it is a severe problem, to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO or DCO shall inform the member that their continued behavior may result in disenrollment from the CCO or DCO;

(D) The CCO or DCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;

(E) The CCO or DCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution, within the laws governing confidentiality;

(F) If the severity of the problem warrants, the CCO or DCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If

necessary, the CCO or DCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The CCO or DCO shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence as the result of his or her special needs or disability, the CCO or DCO shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO or DCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A CCO or DCO-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

(v) Documentation of the CCO or DCO's rationale for concluding that the member's continued enrollment in the CCO or DCO seriously impairs the CCO's or DCO's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO or DCO shall attempt to locate another PCP on their panel who ~~will~~ shall accept the member as their patient. If needed, the CCO or DCO shall obtain an authorization for release of information from the member in order to share the information necessary

for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO or DCO's policies and shall be consistent with CCO or DCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO or DCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements in subsection (c), requests by the CCO or DCO for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56 the CCO or DCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO or DCO's staff so that it seriously impairs the CCO or DCO's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member will ~~may~~ cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO or DCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;

(B) Providers shall immediately notify the CCO or DCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;

(C) The CCO or DCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution, within the laws governing confidentiality;

(D) The CCO or DCO shall provide any additional information requested by the CAR, the Authority, or ~~the Department of Human Services assessment team~~;

(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO or DCO shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (2)(b)(C)(i) of this rule;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO or DCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health

or safety of others; the probability that potential injury to others will may actually occur; and whether reasonable modifications of policies, practices, or procedures will may mitigate the risk to others;

(F) Documentation shall exist that verifies the provider or CCO or DCO immediately reported the incident to law enforcement. The CCO or DCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures will may not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the CCO or DCO's rationale for concluding that the member's continued enrollment in the CCO or DCO seriously impairs the CCO or DCO's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the CCO or DCO's CAR or a team of CARs who may request additional information from Ombudsman Services, AMH, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the AMH's substance use disorder specialist;

(B) In cases where the member is also enrolled in the CCO or DCO's Medicare Advantage plan, the CCO or DCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is insufficient documentation, the CAR shall notify the CCO or DCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the CCO or DCO of the decision within ten working days of receipt of sufficient documentation from the CCO or DCO;

(E) Written decisions shall be sent to the CCO or DCO within 15 working days from receipt of request and sufficient documentation from the CAR.

(56) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO or DCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint ~~(as specified in 410-141-30260 through 410-141-30266.)~~ and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will shall proceed unless the member requests continued enrollment, pending a decision;

(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers ~~or a PCM~~ until such time as they can be enrolled with another CCO or DCO;

(d) If no other CCO or DCO is available to the member, the member will shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO or DCO, the CCO or DCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO or DCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or DCO again requests disenrollment for cause, the request shall be referred to the OHA Authority assessment team for review.

(67) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO or DCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of member's right to file a complaint ~~(as specified in OAR 410-141-3260 through 410-141-3266.)~~ and to request an administrative hearing and the option to continue enrollment in the CCO or DCO pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) The disenrollment effective date will shall be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an Administrative Law Judge's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers ~~or a PCM~~ until such time as they can be enrolled with another CCO or DCO;

(e) If no other CCO or DCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO or DCO, the CCO or DCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO or DCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or DCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.

(78) Other reasons for the CCO or DCO's requests for disenrollment may include the following:

(a) If the member is enrolled in the CCO or DCO on the same day the member is admitted to the hospital, the CCO or DCO shall be responsible for the hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;

(b) The member has surgery scheduled at the time their enrollment is effective with the CCO or DCO, the provider is not on the CCO or DCO's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO or DCO;

(d) Excluding the DCOs, if the CCO determines that the member or MHO member has Third Party Liability (TPL), the CCO ~~will~~ shall contact/report the TPL to the Health Insurance Group (HIG) at www.reportTPL.org. If the member is determined to have active TPL, HIG ~~will~~ shall disenroll the member from the CCO effective the end of the month the TPL is reported; ~~to request disenrollment;~~

(e) If a CCO or DCO has knowledge of a member's change of address, the CCO or DCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO or DCO, if the member no longer resides in the CCO or DCO's service area. Members shall be disenrolled if out of the CCO or DCO's service area for more than three months, unless previously arranged with the CCO or DCO. The effective date of disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO or DCO;

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO or DCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The

Division shall approve requests for disenrollment from CCO or DCOs for members who have been taken into custody;

(g) The member is in a state psychiatric institution.

(89) The Division may initiate and disenroll members as follows:

(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO or DCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the CCO or DCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO or DCO;

(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

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

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;

(b) The Authority may retroactively disenroll enrollment if the member has TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

Stat. Auth.: ORS 413.032, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685