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Date prior to or same as filing date

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

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to become effective [8/1/2012]. Rulemaking Notice was published in the [7/1/2012] Oregon Bulletin.**
Date upon filing or lat Month and Year

RULE CAPTION

Implementation of Coordinated Care Organizations to Provide Care for Medical Assistance Recipients

Not more than 15 words that reasonably identify the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately (000-000-0000)

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

ADOPT: OARs 410-141-3000, 410-141-3010, 410-141-3015, 410-141-3020, 410-141-3030, 410-141-3050, 410-141-3060, 410-141-3070, 410-141-3080, 410-141-3120, 410-141-3140, 410-141-3145, 410-141-3160, 410-141-3170, 410-141-3180, 410-141-3200, 410-141-3220, 410-141-3260, 410-141-3261, 410-141-3262, 410-141-3263, 410-141-3264, 410-141-3268, 410-141-3270, 410-141-3280, 410-141-3300, 410-141-3320, 410-141-3340, 410-141-3345, 410-141-3350, 410-141-3355, 410-141-3360, 410-141-3365, 410-141-3370, 410-141-3375, 410-141-3380, 410-141-3385, 410-141-3390, 410-141-3395 and 410-141-3420

AMEND: OARs 410-141-0000

REPEAL: OARs 410-141-3265 and 410-141-3266

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

Other Auth.: ORS 2011 HB 3650, Chapter 602, Oregon Laws 2011 and 2012 SB 1580

Stats. Implemented: ORS 414.610 - 685, OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

RULE SUMMARY

These rules establish the requirements for Coordinated Care Organizations (CCO) under Oregon's Integrated and Coordinated Health Care Delivery System. CCOs will improve health, increase the quality, reliability, availability and continuity of care, as well as to reduce costs. CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and reduce health disparities. The Authority needs to adopt these rules to establish transitional processes, the application process, application criteria, financial solvency requirements and the client grievance system.

Authorized Signer Printed name Date
*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. **The Oregon Bulletin is published the 1st of each month and updates rules found in the OAR Compilation. For publication in Bulletin, rule and notice filings 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, when filings are accepted until 5:00 pm on the preceding workday. ARC 930-2005

Rule completely rewritten

410-141-0000

Acronyms and Definitions

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

- (1) "Action" means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):
 - (a) The denial or limited authorization of a requested service, including the type or level of service;
 - (b) The reduction, suspension or termination of a previously authorized service;
 - (c) The denial in whole or in part, of payment for a service;
 - (d) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (Division);
 - (e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or
 - (f) For a member who resides in a rural Service Area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain services outside of the participating provider panel:
 - (i) From any other provider (in terms of training, experience and specialization) not available within the network;
 - (ii) From a provider not part of the network who is the main source of a service to the member - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.
 - (iii) Because the only plan or provider available does not provide the service because of moral or religious objections;
 - (iv) Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; or
 - (v) The Authority determines that other circumstances warrant out-of-network treatment moral or religious objections.
- (2) "Appeal" means a request for review of an action.
- (3) "Behavioral Health" means mental health conditions as well as substance abuse disorders.
- (4) "Behavioral health evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance abuse disorder services.
- (5) "Capitated Services" mean those covered services that a PHP or Primary Care Manager (PCM) agrees to provide for a capitation payment under contract with the Authority.
- (6) "Capitation Payment" means:
 - (a) Monthly prepayment to a PHP for health services the PHP provides to members;
 - (b) Monthly prepayment to a PCM to provide primary care management services for a member enrolled with the PCM.
- (7) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.
- (8) "Certificate of Authority" means the certificate, issued by DCBS to a licensed health entity, granting authority to transact insurance as a health insurance company or health care service contractor.
- (9) "Certified or Qualified Health Care Interpreter" means a trained person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into spoken English and readily able to

translate the written or oral statement of other persons into the spoken language of the person with limited English proficiency.

(10) "Chemical Dependency Organization (CDO)" means a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as capitated services under OHP.

(11) "Chemical Dependency Services" mean assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol or other drug abusing or dependent members and their family members or significant others., consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(12) "Cold Call Marketing" means a PCP's or CCO's unsolicited personal contact with a potential member for marketing purposes.

(13) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

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

(15) "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(16) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority's Addictions and Mental Health Division (AMH).

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

(18) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9-CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

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

(20) "Converting MCO" means a CCO that:

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

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

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

(22) "Coordinated Care Services" mean a CCO's fully integrated physical health, behavioral health services pursuant to ORS 414.725 and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

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

(24) "Covered Services" mean medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the Legislature funds, based on the Prioritized List of Health Services.

(25) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment, which is honored when the individual is unable to make such decisions.

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

(27) "Dental Case Management Services" mean services provided to ensure member receives dental services, including a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

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

(29) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection agency.

(30) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(31) "Disenrollment" means the act of removing a member from enrollment with a PHP, PCM, or CCO.

(32) "Enrollment" means the assignment of a member to a PHP, PCM or CCO for management and receipt of health services.

(33) "Exceptional Needs Care Coordination (ENCC)" means a specialized case management service provided by fully capitated health plans to members identified as aged, blind or disabled who have complex medical needs, including:

(a) Early identification of members eligible for ENCC services;

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

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

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

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

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

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

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

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

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

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

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

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

(39) “Health Services” means:

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

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

(40) “Health System Transformation (HST)” means the transformation of health care delivery in medical assistance programs as prescribed by 2011 House Bill 3650, Chapter 602, Oregon Laws 2011 and 2012 Enrolled Senate Bill 1580, Chapter 8, Oregon Laws 2012; and including the CCO Implementation Proposal from the Oregon Health Policy Board (January 24, 2012) approved by Section 2 of 2012 Enrolled Senate Bill 1580.

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

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

(43) “Marketing” means any communication from a PHP or a CCO to a client who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted to be an attempt to influence the OHP client:

(a) To enroll in that particular PHP or CCO;

(b) To either disenroll or not to enroll with another PHP or CCO.

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

(45) “Mental Health Assessment” means a qualified mental health professional's determination of a member's need for mental health services.

(46) “Mental Health Case Management” means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers.

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

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

- (49) "Net Premium" means the premium, net of reinsurance premiums paid, HRA and GME payments and MCO tax expenses.
- (50) "Non-Participating Provider" means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.
- (51) "OHA or Authority Reporting CCO" means a CCO that reports its solvency plan and financial status to the Authority under these rules.
- (52) "Participating Provider" means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.
- (53) "PCM Member" means a client enrolled with a primary case manager.
- (54) "Peer Wellness Specialist" means an individual who assists behavioral health services consumers to reduce stigmas and discrimination and to provide direct services to assist individuals to create and maintain recovery, health and wellness by:
- (a) Assessing the individual's behavioral health service and support needs through community outreach;
 - (b) Assisting individuals with access to available services and resources; and
 - (c) Addressing barriers to services and providing education and information about available resources and behavioral health issues.
- (55) "Person Centered Care" means care that reflects the individual patient's strengths and preferences; reflects the clinical needs of the patient as identified through an individualized assessment; is based upon the patient's goals; and will assist the patient in achieving the goals.
- (56) "Personal Health Navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.
- (57) "Physician Care Organization (PCO)" means a PHP that contracts with the Authority to provide partially-capitated health services under OHP, exclusive of inpatient hospital services.
- (58) "Potential Member" means an OHP client who meets the requirements set forth in ORS 414.631 to be in a coordinated care organization.
- (59) "Premium" means:
- (a) CCO payment when the payment is made by the Authority to the CCO, for purposes of OAR 410-141-3340 to 410-141-3395;
 - (b) Also includes any other revenue received by the CCO for the provision of healthcare services over a defined period of time.
- (60) "Primary Care Management Services" mean services that ensure PCM members obtain health services that are necessary to maintain physical and emotional development and health.
- (61) "Primary Care Manager (PCM)" means a primary care provider who agrees to provide primary care management services to their members.
- (62) "Prioritized List of Health Services" mean the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.
- (63) "Service Area" means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.
- (64) "Treatment Plan" for behavioral health consists of the following three components:
- (a) "Emergency Response System" means the coordinated method of triaging the mental health service needs of members and providing covered services when needed. The system operates 24-hours a day, 7-days a week and includes, but is not limited to, after hours on call staff, telephone and in person screening, outreach, and networking with hospital emergency rooms and police.
 - (b) "Emergency Services" means covered services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency situation.
 - (c) "Services Coordination" means services provided to members who require access to and/or receive services from one or more Allied Agencies or program components according to the

treatment plan. Services provided may include establishing pre-commitment service linkages; advocating for treatment needs; and providing assistance in obtaining entitlements based on mental or emotional disability.

(65) "Treatment Plan" for physical and dental health" consists of the following two components:

(a) "Emergency Services related to physical health" means services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

(b) "Services Coordination" means services provided to members who require access to and receive covered services, or long term care services, or from one or more Allied Agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages; advocating for treatment needs; and providing assistance in obtaining entitlements based on mental or emotional disability;

(66) "Service Authorization Request" means a member's initial or continuing request for the provision of a service, including member requests made by their provider or the member's authorized representative.

(67) "Valid Pre-Authorization" means a document the Authority, a PHP or CCO receives requesting a health service for a client who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months; and

(b) All data fields required for processing of the request or payment of the service, including the appropriate billing codes.

[Publications: Publications referenced are available from the agency.]

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3000

Definitions

The Oregon Health Authority adopts and incorporates by reference the definitions in the following administrative rules and applies them to Health System Transformation and the use of Coordinated Care Organizations:

(1) OAR 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;

(2) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and

(3) OAR 410-141-0000, definitions of the Oregon Health Plan's rules generally applicable to prepaid managed health care organizations and coordinated care organizations.

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

Stats. Implemented: ORS 414.610 – 685

410-141-3010

CCO Application, Certification, and Contracting Procedures

(1) The following definitions apply to this rule:

(a) "Applicant" means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services;

(b) "Application" means an entity's written response to a Request for Application (RFA);

- (c) "Award date" means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts;
- (d) "Certification" means the Authority's determination that an entity meets the standards, set forth in the RFA, for being a CCO, through initial certification or recertification;
- (e) "Coordinated Care Services" means fully integrated physical health services, chemical dependency and mental health services, and shall include dental health services as provided in ORS 414.625(3), by July 1, 2014;
- (f) "CMS Medicare/Medicaid Alignment Demonstration" means a demonstration proposal by the Authority to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent feasible for individuals who are eligible for both programs. The Authority and CMS shall jointly establish its timelines and requirements for participation in the Demonstration;
- (g) "Entity" means a single legal entity capable of entering into a risk contract that covers coordinated care services with the State and conducting the business of a coordinated care organization;
- (h) "Request for Applications (RFA)" means the document used for soliciting applications for certification as a CCO, award of or amendment of a contract coordinated care services, or other objectives as the Authority may determine appropriate for procuring coordinated care services.
- (2) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.
- (3) The Authority shall use the following RFA processes for CCO certification and contracting:
- (a) The Authority shall provide public notice of every RFA on its Web site. The RFA shall indicate how prospective applicants shall be made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities, or upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;
- (b) The RFA process begins with a public notice of the RFA, which shall be communicated using the Authority's website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested and a sample contract;
- (c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;
- (d) The RFA may request applicants to appear at a public meeting to provide information about the application;
- (e) The RFA will request information from applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;
- (f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require submission of the application on its web portal in accordance with OAR 137-047-0330 (Electronic Procurements). If electronic procurement is used, applications shall be accepted only from applicants who accept the terms and conditions for use of the Authority's web portal.
- (4) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity, or other purposes within the scope of the RFA;
- (5) The Authority shall evaluate applications for certification on the basis of information contained in the RFA, the application and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;
- (a) The Authority may enter into negotiation with Applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;

- (b) The Authority shall notify each applicant that applies for certification of its certification status;
- (c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.
- (6) Review for certification:
 - (a) The Authority shall issue certification to only applicants that meet the requirements and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;
 - (b) The Authority determines an applicant is eligible for certification when the applicant meets the requirements of the RFA, including written assurances, satisfactory to the Authority, that the applicant:
 - (A) Provides or will provide the coordinated care services in the manner described in the RFA and the Authority's rules;
 - (B) Is responsible and meets or will meet standards established by the Authority and DCBS for financial reporting and solvency;
 - (C) Is organized and operated, and shall continue to be organized and operated, in the manner required by the contract and described in the application; and
 - (D) Shall comply with any assurances it has given the Authority.
- (7) The Authority shall certify CCOs for a period of six years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.
- (8) The Authority may determine that an applicant is potentially eligible for certification in accordance with section (9). The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient applicants eligible for certification are available to attain the Authority's objectives under the RFA.
- (9) The Authority may determine that an applicant is potentially eligible for certification if:
 - (a) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period of time; and
 - (b) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for certification. The Authority shall determine the date and required documentation and written assurances required from the applicant;
 - (c) If the Authority determines that an applicant potentially eligible for certification cannot become certified within the time announced in the RFA for contract award, the Authority may:
 - (A) Offer certification at a future date when the applicant demonstrates, to the Authority's satisfaction, that the applicant is eligible for certification within the scope of the RFA; or
 - (B) Inform the applicant that it is not eligible for certification.
- (10) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.
- (11) The Authority shall enter into or renew a contract with a CCO only if the CCO has been certified and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System, which includes but is not limited to:
 - (a) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda;
 - (b) The number of CCOs in the region.
- (12) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:
 - (a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(b) Only an entity that the Authority has certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO that it will be offered a CCO contract;

(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified applicants, in order to meet Authority's needs including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA;

(d) Subject to any limitations in the RFA, the Authority may renew a contract for CCO services by amending an existing contract or issuing a replacement contract, without issuing a new RFA;

(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.

(13) Disclosure of application contents and release of information:

(a) Except for the letter of intent to apply, and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), application information may not be disclosed to any applicant or the public until the award date. No information may be given to any applicant or the public relative to its standing with other applicants before the award date, except under the following circumstances:

(A) The information in the application may be shared with the Authority, DCBS, CMS, and those individuals involved in the application review and evaluation process; and

(B) Information may be provided by the applicant to the public as part of a public review process.

(b) Application information may be disclosed on the award date, with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA, and if the Authority determines it meets the disclosure exemption requirements.

(14) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the Demonstration requirements. Upon approval of the Demonstration by CMS, the Authority shall conduct, jointly with CMS, the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and award of three-way contracts between CMS, the state, and applicants who have been certified to contract as a CCO and participate in the Demonstration.

(15) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts.

(16) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following DOJ Model Public Contract Rules (as in effect on January 1, 2012) to govern RFAs and certification and contracting with CCOs:

(a) OAR 137-046 -- General Provisions Related to Public Contracting: 137-046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 -- Public Procurements for Goods or Services: OAR 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review) and OAR 137-047-0800;

(c) In applying the DOJ Model Rules to RFAs under this rule:

(A) An application is a proposal under the DOJ Model Rules;

(B) An RFA is an RFP under the DOJ Model Rules;

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;

(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.

(17) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review. Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3015

Certification Criteria for Coordinated Care Organizations

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System, including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO certification within the context of the Oregon Health Policy Board's report, *Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation* (Jan. 24, 2012).

(3) Applicants must describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above \$250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and to the CCO's strategic plan for developing its community health assessment and community health improvement plan:

- (a) In all cases, CCOs must have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;
- (b) Each criterion will be listed, followed by the elements that must be addressed during the initial certification described in this rule, without limiting the information that is requested in the RFA concerning these criteria.
- (6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant must:
- (a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, the criteria used to select governance structure members; and how it will assure transparency in governance;
- (b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;
- (c) Describe how its governance structure will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded long-term care services and supports.
- (7) Each CCO must convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant must clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC will be administered to achieve the goals of community involvement and the development, adoption and updating of the community health assessment and community health improvement plan.
- (8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:
- (a) Since community health assessments will evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before becoming certified;
- (b) The applicant shall describe how it will develop its health assessment, meaningfully, and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community need that builds on community resources and skills and emphasizes innovation.
- (9) The CCO must describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.
- (10) Dental care organizations: On or before July 1, 2014, each CCO shall have a contractual relationship with any DCO in its service area.
- (11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed, unless good cause can be shown:
- (a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;
- (b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met, unless good cause is shown why an agreement is not feasible.

(12) CCOs must provide integrated person-centered care and services designed to provide choice, independence and dignity:

(a) The applicant must describe its strategy to assure that each member receives integrated person-centered care and services designed to provide choice, independence and dignity;

(b) The applicant must describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.

(13) CCOs must develop mechanisms to monitor and protect against underutilization of services and inappropriate denials; provide access to qualified advocates; and promote education and engagement to help members be active partners in their own care. Applicants must:

(a) Describe their planned or established policies and procedures that protect member rights, including access to qualified peer wellness specialists, personal health navigators, and qualified community health workers where appropriate;

(b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.

(14) CCOs must operate in a manner that encourages patient engagement, activation and accountability for the member's own health. Applicants shall describe how they plan to:

(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;

(b) Ensure that member choices are reflected in the development of treatment plans and member dignity is respected.

(15) CCOs must assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services. CCOs and their network providers must work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all members:

(a) Applicants must describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and chemical dependency services providers, and dental care when the CCO includes a dental care organization, and to facilitate access to community social and support services, including DHS Medicaid-funded long-term care services, mental health crisis services and culturally and linguistically appropriate services;

(b) Applicants must describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.

(16) CCOs must assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(17) CCOs must address the supportive and therapeutic needs of each member in a holistic fashion, using patient-centered primary care homes and individualized care:

(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans, particularly for members with intensive care coordination needs, and screen for all other issues including mental health;

(b) Applicants shall describe how its implementation of individualized care plans reflects member or family/caregiver preferences and goals to ensure engagement and satisfaction.

(18) CCOs shall assure that members receive comprehensive transitional health care, including appropriate follow-up care, when entering or leaving an acute care facility or long-term care setting. Applicants shall:

(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care and members' experience of care and outcomes are improved;

(b) Demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;

(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and Persons with Disabilities concerning care coordination and transition strategies for members.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources, including the use of certified or qualified health care interpreters, community health workers and personal health navigators. The applicant must describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate and community health workers.

(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations. Applicants must describe:

(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;

(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;

(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.

(21) Each CCO shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency, including members with severe and persistent mental illness covered under the State's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant must describe how it will:

(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;

(b) Reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.

(22) Each CCO shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.

(23) Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations:

(a) The applicant must describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services, and that members are fully informed partners in transitioning to this model of care;

(b) The applicant shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.

(24) CCOs' health care services must focus on achieving health equity and eliminating health disparities. Applicants must:

(a) Describe their strategy for ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Department.

(25) CCOs are encouraged to use alternative payment methodologies, consistent with ORS 414.653. The applicant must describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for members.

(26) Each CCO shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant must describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and its HIT improvement plan for meeting transformation expectations;

(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct enabled health information service provider.

(27) Each CCO must report on outcome and quality measures identified by the Authority under ORS 414.638 and participate in the All Payer All Claims (APAC) data reporting system. The applicant must provide assurances that:

(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;

(b) It will submit APAC data in a timely manner according to program specifications.

(28) Each CCO shall be transparent in reporting progress and outcomes. Applicants must:

(a) Describe how it will assure transparency in governance;

(b) Agree to timely provide access to certain financial, outcomes, quality and efficiency metrics that will be transparent and publicly reported and available on the internet.

(29) Each CCO shall use best practices in the management of finances, contracts, claims processing, payment functions and provider networks. The applicant must describe:

(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;

(b) Whether the CCO will use a clinical advisory panel (CAP) or other means to ensure clinical best practices;

(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements, and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

(30) Each CCO must demonstrate sound fiscal practices and financial solvency, and must possess and maintain resources needed to meet their obligations:

(a) Initially, the financial applicant must submit required financial information that allows the DCBS, Insurance Division, on behalf of the Authority, to confirm financial solvency and assess fiscal soundness;

(b) The applicant shall provide information relating to assets and financial and risk management capabilities.

(31) Each CCO may provide coordinated care services within a global budget. Applicants must submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.

(32) CCO shall operate, administer and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant must provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

(33) Each CCO shall provide covered Medicaid services, other than DHS Medicaid-funded long-term care services, to members who are dually eligible for Medicare and Medicaid. The applicant may participate in the CMS Medicare/Medicaid Alignment Demonstration, if the Authority obtains necessary federal approvals.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3020

Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation and Rule Precedence

(1) The Authority and its Division of Medical Assistance Programs (Division) and Addictions and Mental Health Division (AMH) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Oregon Integrated and Coordinated Health Care Delivery System and medical assistance programs. This includes the Oregon Health Plan (OHP) pursuant to ORS Chapter 414, subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, the Authority shall construe them as much as possible to be consistent. In the event that Authority policies, procedures, rules, and interpretations are inconsistent, the Authority shall apply the following order of precedence:

(a) For purposes of the provision of covered coordinated care services to Authority clients, including but not limited to authorizing and delivering service, or denials of authorization or services, the Authority, clients, enrolled providers, and the CCOs shall apply the following order of precedence:

(A) Consistent with ORS 413.071 and notwithstanding any other provision of state law, those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services (CMS) shall govern the administration of the medical assistance programs;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for CCOs, requirements applicable to providing coordinated care services to members are provided in this rule, the Division's General Rules, OAR 410-120-0000 through 410-120-1980 and the provider rules applicable to the category of health service;

(D) Generally for enrolled fee-for-service providers, requirements applicable to the provision of covered medical assistance to clients are provided in the Division's General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage set forth in OAR chapter 410 division 141 and the provider rules applicable to the category of health service;

(E) Any other applicable properly promulgated rules adopted by the Division, AMH and other offices or units within the Authority necessary to administer medical assistance programs, such as Electronic Data Transaction rules in OAR 943-120-0100 through 943-120-0200; and

(F) The basic framework for provider enrollment in OAR chapter 943 division 120 and chapter 410 division 120 generally applies to providers enrolled with the Authority, subject to more specific

requirements applicable to the administration of medical assistance programs. For purposes of this rule, “more specific” means the requirements, laws, and rules applicable to the provider type and covered health services.

(b) For purposes of contract administration solely between the Authority and its CCOs, the contract terms and the requirements in section (2)(a) of this rule governing the provision of covered coordinated health services to clients.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3030

Implementation and Transition

Implementation of the Oregon Integrated and Coordinated Health Care Delivery System through CCOs is essential to achieve the objectives of health transformation and cost savings. The ability of CCOs to meet transformation expectations will be phased in over time to allow CCOs to develop the necessary organizational infrastructure. During this initial implementation period, the Authority holds the following expectations:

(1) Contract provisions, including an approved CCO strategy or plan for implementing health services transformation, shall describe how the CCO must comply with transformation requirements under these rules.

(2) Local and community involvement is required, and the Authority will work with CCOs to achieve flexibilities that may be appropriate to achieve community-directed objectives, including addressing health care for diverse populations.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3050

CCO Enrollment for Certain Children Receiving Health Services

Pursuant to OAR 410-141-3060, the Department or Oregon Youth Authority (OYA) shall select CCOs for a child receiving Department or OYA services in an area where a CCO is available. If a CCO is not available in an area, the Authority or the Department shall enroll the child in accordance with OAR 410-141-0050.

(1) The Authority shall, to the maximum extent possible, ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority, unless the Authority authorizes disenrollment from a CCO:

(a) Except as provided in OAR 410-141-3060 (Coordinated Care Enrollment Requirements), OAR 410-141-3080 (Disenrollment from Coordinated Care Health Plans) or ORS 414.631(2) children are not exempt from mandatory enrollment in a CCO on the basis of third party resources (TPR) coverage;

(b) The Authority shall review decisions to use fee-for-service (FFS) open card for a child if the child's circumstances change and at the time of redetermination consider whether the Authority or the Department shall enroll the child in a CCO.

(2) When a child is transferred from one CCO to another CCO or from FFS or a PHP to a CCO, the CCO must facilitate coordination of care consistent with OAR 410-141-3160:

(a) CCOs must work closely with the Authority to ensure continuous CCO enrollment for children;

(b) If the Authority determines that it should disenroll a child from a CCO, the CCO shall continue to provide health services until the Authority's established disenrollment date to provide for an adequate transition to the next CCO.

(3) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to the CCO's service area at the end of the temporary placement;

(b) A CAF child receiving behavioral rehabilitation services (BRS) is considered a temporary placement;

(c) Children in OYA custody enroll with the CCO serving the geographic area of placement. OYA representatives may request an SAE to maintain CCO coverage on a placement they consider temporary.

(4) If the Authority or the Department enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall pay for covered health services during that placement, even if the location of the facility is outside the CCO's service area:

(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment;

(b) Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO, unless the provisions in OAR chapter 410 division 141 apply;

(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority or Department shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.

(5) Except for OAR 410-141-3060 and 410-141-3080, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

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 health care services on a fee-for-service basis but 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.

(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 services on a fee-for-service basis.

(11) A client must enroll in a dental care organization (DCO) in a service area where a DCO has adequate dental care access and capacity, and a 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 mental (behavioral) health organization (MHO) in a service area where MHO enrollment is required. The following determines if a service area requires MHO enrollment:

- (a) The service area has adequate behavioral health care access and capacity;
- (b) A CCO does not serve in the area; or
- (c) A CCO serves the area, but the CCO has inadequate health care access and capacity to accept new members:

(14) 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.

(15) 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.

(16) 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.

(17) 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.

(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.

(18) 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;

(b) From August 1, 2012, until January 1, 2013, newly eligible women who are in their third trimester of pregnancy are exempt for up to 60 days after their children's birth. Beginning January 1, 2013, enrollment is required;

- (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.
- (19) 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;
- (20) 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.
- (21) 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.
- (22) 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 414.032, 414.615, 414.625, 414.635, 414.651
- Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3070

Pharmaceutical Drug List Requirements

- (1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. CCOs shall pay for prescription drugs, except:
- (a) As otherwise provided, mental health drugs that are in Class 7 & 11 (based on the National Drug Code (NDC)) as submitted by the manufacturer to First Data Bank);
- (b) Depakote, Lamictal, and those drugs that the Authority specifically carved out from capitation according to sections (8) and (9) of this rule;
- (c) Any applicable co-payments;
- (d) For drugs covered under Medicare Part D when the client is fully dual eligible.
- (2) CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337. CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:
- (a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;
- (b) Include at least one item in each therapeutic class of over-the-counter medications; and
- (c) Be revised periodically to assure compliance with this requirement.
- (3) CCOs shall provide their participating providers and their pharmacy subcontractor with:
- (a) Their drug list and information about how to make non-drug listed requests;

- (b) Updates made to their drug list within 30 days of a change that may include but are not limited to:
- (A) Addition of a new drug;
 - (B) Removal of a previously listed drug; and
 - (C) Generic substitution.
- (4) If a drug cannot be approved within the 72-hour time requirement for prior authorization and the medical need for the drug is immediate, CCOs must provide, within 24 hours of receipt of the drug prior authorization request, for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.
- (5) CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider, if the approved prescriber certifies medical necessity for the drug such as:
- (a) The equivalent of the drug listed has been ineffective in treatment; or
 - (b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.
- (6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.
- (7) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs which have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. The DESI LTE drug list is available at: <http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12LTEIRS Drugs.asp>.
- (8) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:
- (a) The drug name;
 - (b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and
 - (c) The reason that the Authority should consider this drug for carve out.
- (9) If a CCO request s that a drug not be paid within the global budget the Authority shall exclude the drug from global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.
- (10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services Program rules (chapter 410, division 121). A CCO may not reimburse providers for carved out drugs.
- (11) CCOs shall submit quarterly utilization data, within 60 days of the date of service, as part of the CMS Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.
- (12) CCOs may not provide payment for drugs made by manufacturers that do not have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program.
- Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3080

Disenrollment from Coordinated Care Organizations

- (1) At the time of recertification, a client may disenroll from one CCO in a service area and enroll in another CCO in that service area. The primary person in the household shall make this decision on behalf of all household members on the same household case. If the client is not able to make this decision, the client's representative shall do so. The client may request this either orally or in writing.

(2) A member who moves from one service area to another service area shall disenroll from the CCO in the previous service area and enroll with a CCO 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 voluntarily enrolls in a CCO per OAR 410-141-3060 (19) may disenroll from their CCOs at any time and receive health care services on a fee-for-service basis or enroll in another CCO 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;

(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 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 assignment:

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

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

(c) Clients may change their CCO assignment upon eligibility redetermination.

(7) Pursuant to CFR 438.56, the CCO 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 care with which the CCO 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 seriously impairs the CCO's ability to furnish services to this particular member or other members.

(8) A CCO may request the Authority to disenroll a member if the CCO 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 determines:

(A) The member has moved to a service area the CCO does not serve;

(B) The member is out of the CCO's area for three months without making arrangements with the CCO;

(C) The member did not initiate enrollment in the CCO 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 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 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 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 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 requests disenrollment.

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

(11) The CCO 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 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 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, 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 service area. The Authority shall recoup the balance of that month's capitation payment from the CCO;

(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 client'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;
- (b) Transfer of a member from a CCO to another CCO; or
- (c) Automatic enrollment of a member in a CCO.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3120

Operations and Provision of Health Services

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

(2) At a minimum, CCOs must provide medically appropriate health services, including flexible services, within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the contract.

(3) CCOs must select providers using universal application and credentialing procedures and objective quality information. CCOs must take steps to remove providers from their provider network that fail to meet objective quality standards:

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and recredentialed no less frequently than every three years. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank. CCOs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;

(b) CCOs must screen their providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes;

(c) CCOs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be responsible for the following activities, including oversight of the following processes, regardless of whether the activities are provided directly, contracted or delegated:

(A) Ensuring that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They must ensure participating providers are appropriately supervised according to their scope of practice;

(B) Providing training for CCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(d) The CCO must provide accurate and timely information to the Authority about:

(A) License or certification expiration and renewal dates;

(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension or certification sanction;

(C) If a CCO knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere").

(e) CCOs may not refer members to or use providers that:

(A) Have been terminated from the Division;

(B) Have been excluded as a Medicaid provider by another state;

(C) Have been excluded as Medicare/Medicaid providers by CMS; or

(D) Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.

(f) CCOs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. CCOs must recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction or termination;

(g) CCOs must require each atypical provider to be enrolled with the Authority and must obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. CCOs must require each qualified provider to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPES);

(h) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

(4) A CCO may not discriminate with respect to participation in the CCO against any health care provider who is acting within the scope of the provider's license or certification under applicable state law, on the basis of that license or certification. If a CCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This rule may not be construed to:

(a) Require that a CCO contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or

(b) Preclude the CCO from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation, including price.

(5) A CCO shall establish an internal review process for a provider aggrieved by a decision under subsection (4) of this rule, including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.

(6) To resolve appeals made to the Authority under sections (4) and (5) of this rule, the Authority shall provide administrative review of the provider's appeal, using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the CCO to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority must consider the CCO's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(7) A prevailing party in an appeal under sections (4) through (6) of this rule shall be awarded the costs of the appeal.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3140

Emergency and Urgent Care Services

(1) CCOs shall have written policies, procedures, and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all members. CCOs shall:

- (a) Communicate these policies and procedures to participating providers;
- (b) Regularly monitor participating providers' compliance with these policies and procedures; and
- (c) Take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or dentally appropriate response as indicated to urgent or emergency calls including but limited to the following:

- (a) Telephone or face-to-face evaluation of the member;
- (b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;
- (c) Development of a course of action;
- (d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound;
- (e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and
- (f) Provision for notifying other providers, when necessary, to request approval to treat members.

(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.

(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:

- (a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;
- (b) The CCO may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;
- (c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not billed within ten calendar days of the service.

(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:

- (a) Pre-authorized by the CCO;
 - (b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or
 - (c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.
 - (6) The CCO's responsibility for post-stabilization care it has not authorized ends when:
 - (a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's care;
 - (b) The participating provider assumes responsibility for the member's care through transfer;
 - (c) A CCO representative and the treating provider reach an agreement concerning the member's care; or
 - (d) The member is discharged.
 - (7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for dental health care.
 - (a) CCOs shall educate members about how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;
 - (b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.
 - (8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.
- Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3145

Community Health Assessment and Community Health Improvement Plans

- (1) CCOs must partner with their local public health authority, local mental health authority and hospital systems to develop a shared community health assessment process, including conducting the assessment and development of the resulting community health improvement plan (plan).
- (2) CCOs must work with the Authority, to identify the components of the community health assessment. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, using existing resources when available and avoiding duplication where practicable.
- (3) In developing and maintaining a health assessment, CCOs must meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including but not limited to the following:
 - (a) Emphasis on disproportionate, unmet, health-related need;
 - (b) Emphasis on primary prevention;
 - (c) Building a seamless continuum of care;
 - (d) Building community capacity;
 - (e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a community health assessment and community health improvement plan will be met for purposes of this law if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007 and the community health assessment and community health improvement plan requirements for local health departments of the Public Health Accreditation Board, and worked with AAA and local mental health authority.

(5) The CCO's Community Advisory Council shall oversee the community health assessment and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the Plan.

(6) The plan adopted by the Council must describe the scope of the activities, services and responsibilities that the CCO shall consider upon implementation. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

(7) CCOs and their participating providers must work together to develop best practices of culturally and linguistically appropriate care and service delivery to eliminate health disparities and improve member health and well-being.

(8) Through their community health assessment and plan, CCOs shall identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting, including but not limited to home, independent support living, adult foster home or homeless. CCOs shall collect and maintain data on race, ethnicity and primary language for all members on an ongoing basis in accordance with standards established jointly by the Authority and the Department. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCO's shall make this information available by posting on the web.

(9) CCOs shall develop and review and update its community health assessment and plan every three years to ensure the provision of all medically appropriate covered coordinated care services, including urgent care and emergency services, preventive, community support and ancillary services, in those categories of services included in CCO contracts or agreements with the Authority.

(10) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. CCOs shall document all monitoring and corrective action activities.

(11) Should there be more than one CCO in a community, the CCOs and their community partners may work together to develop one shared community health assessment and one shared Plan.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3160

Integration and Care Coordination

(1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must assure that physical, behavioral and oral health services are consistently

provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan (Plan). CCOs must develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:

(a) CCOs shall ensure the provision of care coordination, treatment engagement, preventive services, community based services, behavioral health services and follow up services for all members with behavioral health conditions;

(b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013 and must notify the Authority within 30 calendar days of executing the contract;

(c) By July 1, 2014, each CCO must have a contractual relationship with any dental care organization that serves members in the area where they reside;

(d) CCOs must have adequate, timely and appropriate access to hospital and specialty services. CCOs must establish hospital and specialty service agreements that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services, performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments;

(e) CCOs must demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care. CCOs shall ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings and the state hospital.

(2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:

(a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type.

(b) Ensure that members with high health needs, multiple chronic conditions, or behavioral health issues are involved in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(c) Use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the state's 1915(1) State Plan Amendment, and those receiving DHS Medicaid-funded long-term care services. Plans should reflect member family, or caregiver preferences and goals to ensure engagement and satisfaction;

(d) Implement systems to assure and monitor improved transitions in care so that members receive comprehensive transitional care, and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care;

(e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);

(f) Work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs;

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

(3) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:

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

(b) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology, where available;

(c) CCOs must engage other primary care provider (PCP) models to be the primary point of care and care management for members, where there is insufficient PCPCH capacity;

(d) CCOs must develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall ensure that all other services and supports are provided as close to the member's residence as possible.

(4) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO must demonstrate that the other model of patient-centered primary health care shall assure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

(5) If the member is living in a DHS Medicaid funded long-term care (LTC) nursing facility or community based care facility, or other residential facility, the CCO must communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services:

(a) The CCO shall establish procedures for coordinating member health services, and how it will work with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;

(b) CCOs shall coordinate transitions to DHS Medicaid-funded long-term care by communicating with local AAA/APD offices when members are being discharged from an inpatient hospital stay, or transferred between different LTC settings;

(c) CCOs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members' receiving Medicaid-funded LTC services.

(6) For members who are discharged to post hospital extended care, at the time of admission to a skilled nursing facility (SNF) the CCO shall notify the appropriate AAA/APD office and begin appropriate discharge planning. The CCO shall pay for the post hospital extended care benefit if the member was a member of the CCO during the hospitalization preceding the nursing facility placement. The CCO shall notify the SNF and the member no later than two working days before discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the CCO shall notify the appropriate AAA/APD office when the CCO learns of the admission.

(7) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service or PHP to a CCO, the CCO shall make every reasonable effort within the laws governing confidentiality to coordinate, including but not limited to ORS 414.679 transfer of the OHP client into the care of a CCO participating provider.

(8) CCOs shall establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to

ensure member access to mental health services, some of which are not provided under the global budget.

(9) CCOs shall coordinate a member's care even when services or placements are outside the CCO service area. CCO assignment is based on the case member's residence, and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department or health services placements for services including residential placements may be located out of the service area, however, the CCO shall coordinate care while in placement and discharge planning for return to county of origin or jurisdiction. For out of area placements, an out of area exception must be made for the member to retain the CCO enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.

(10) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs such as secure residential facilities, PASSAGES projects, or state hospital, shall receive follow-up services as medically appropriate to ensure discharge within five working days of receipt of notice of discharge readiness.

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

(12) CCOs shall accept FFS authorized services, medical, and pharmacy prior authorizations, ongoing services where a FFS prior authorization is not required, and services authorized by the Division's Medical Management Review Committee for 90 days, or until the CCO can establish a relationship with the member and develop an evidence based, medically appropriate coordinated care plan, whichever is later, except where customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

(13) Except as provided in OAR 410-141-3050, CCOs shall coordinate patient care, including care required by temporary residential placement outside the CCO service area, or out-of-state care in instances where medically necessary specialty care is not available in Oregon:

(a) CCO enrollment shall be maintained in the county of origin with the expectation of the CCO to coordinate care with the out of area placement and local providers;

(b) The CCO shall coordinate the discharge planning when the member returns to the county of origin.

(14) CCOs shall coordinate and authorize care, including instances where the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3170

Intensive Care Coordination Services (Exceptional Needs Care Coordination (ENCC))

(1) CCOs are responsible for intensive care coordination services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the CCO uses another term, these rules set forth the elements and requirements for intensive care coordination services. Where the term ENCC appears in rule or contract, it shall be given the meaning in this rule.

(2) CCOs shall make intensive care coordination services available to members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health

issues receiving home and community-based services under the state's 1915(1) State Plan Amendment. The member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager may request intensive care coordination services. (3) CCOs shall respond to requests for intensive care coordination services with an initial response made by the next working day following the request.

(4) CCOs shall periodically inform all participating providers of the availability of intensive care coordination services, provide training for patient centered primary care homes and other primary care providers' staff on intensive care coordination services and other support services available for members.

(5) CCOs shall ensure that the case manager's name and telephone number are available to Authority staff and members or member representatives when intensive care coordination services are provided to the member.

(6) CCOs shall make intensive care coordination services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting.

(7) CCOs shall implement procedures to share the results of its identification and assessment of any member appropriate for intensive care coordination services, with participating providers serving the member so that those activities are not duplicated. Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(8) CCOs must have policies and procedures, including a standing referral process for direct access to specialists, for identifying, assessing and producing a treatment plan for each member identified as having a special health care need. Each treatment plan shall be:

(a) Developed by the member's designated provider with the member's participation;

(b) Include consultation with any specialist caring for the member;

(c) Approved by the CCO in a timely manner if CCO approval is required; and

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

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3180

Record Keeping and Use of Health Information Technology

(1) CCOs shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC §1320-d et seq., and the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. CCOs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(2) A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices. CCO's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member seeks copies of their records.

(3) Notwithstanding ORS 179.505, a CCO, its provider network and programs administered by the Department 's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and

reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the members.

(4) A CCO and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and behavioral health diagnoses, within the CCO for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the CCO and the CCO's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements including the Authority's rules established in OAR 943-014-0000 through 0070 for matters that involve privacy and confidentiality and privacy of members protected information.

(5) The CCO must document its methods and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports:

- (a) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery;
- (b) The supportive and therapeutic needs of the member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;
- (c) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility, including acute psychiatric facility, state hospital or residential care settings for members with mental illness or a DHS Medicaid funded long-term care setting, including engagement of the member and family in care management and treatment planning;
- (d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, for example, the use of certified or qualified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;
- (e) Members have access to advocates, for example, qualified 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;
- (f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(6) CCOs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, CCOs shall:

- (a) Identify EHR adoption rates; rates may be divided by provider type and geographic region;
- (b) Develop and implement strategies to increase adoption rates of certified EHRs;
- (c) Encourage EHR adoption.

(7) CCOs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and dental health information with any other provider in that CCO.

(8) CCOs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

(9) CCOs shall initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:

- (a) Analytics that are regularly and timely used in reporting to its provider network (e.g. to assess provider performance, effectiveness and cost-efficiency of treatment);
- (b) Quality and utilization reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the Authority to monitor the CCOs performance);
- (c) Patient engagement through HIT (using existing tools such as e-mail); and

(d) Other appropriate uses for HIT (e.g. telehealth, mobile devices).

(10) CCOs shall maintain health information systems that collect, analyze, integrate, and report data and can provide information on areas including but not limited to the following:

(a) Names and phone numbers of the member's primary care provider or clinic, primary dentist and behavioral health provider;

(b) Copies of Client Process Monitoring System (CPMS) enrollment forms;

(c) Copies of long-term psychiatric care determination request forms;

(d) Evidence that the member has been informed of rights and responsibilities;

(e) Complaint and appeal records;

(f) Disenrollment requests for cause and the supporting documentation;

(g) Coordinated care services provided to enrollees, through an encounter data system; and

(h) Based on written policies and procedures, the record keeping system developed and maintained by CCOs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system to allow the CCO to ensure that data received from providers is accurate and complete by:

(A) Verifying the accuracy and timeliness of reported data;

(B) Screening the data for completeness, logic, and consistency; and

(C) Collecting service information in standardized formats to the extent feasible and appropriate.

(11) CCOs and their provider network shall cooperate with the Division, AMH, the Department of Justice Medicaid Fraud Unit, and CMS, or other authorized state or federal reviewers, for purposes of audits, inspection and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.

(12) Across the CCO's provider network, all clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records must be retained until all issues arising out of the action are resolved.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3200

Outcome and Quality Measures

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

(2) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority.

(3) CCOs shall address objective outcomes, quality measures, and benchmarks, for ambulatory care, inpatient care, behavioral health treatment, oral health care (to the extent that dental services are the responsibility of a CCO under an agreement with a DCO) and all other health services provided by or under the responsibility of the CCO, as specified in the CCO's contract with the Authority.

(4) CCOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to members consistent with the needs and priorities identified in the CCO's community health assessment, community health improvement plan, and the standards in the CCO's contract. CCOs must have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction;

(c) Evaluate grievance, appeals and contested case hearings, consistent with OAR 410-141-3266; and

(d) Assess the quality and appropriateness of coordinated care services provided to members who are aged, blind or disabled, who have high health care needs, multiple chronic conditions, mental illness or chemical dependency; who received Medicaid funded long term care benefits; or who are children receiving CAF (Child Welfare) or OYA services.

(5) CCOs must implement policies and procedures that assure it will timely collect data including health disparities and other data required by rule or contract that will allow the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO, or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(6) CCOs must adopt practice guidelines consistent with 42 CFR 438.236 that address physical health care, behavioral health treatment or dental care concerns identified by members or their representatives and to implement changes which have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.

(7) CCOs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures will be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health);

(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation and require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

(8) CCOs must provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

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, 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) — Seen or treated within 24-hours;

- (e) Urgent dental care (when dental care is provided by the CCO) — 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) — 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 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 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3260

Grievance System: Grievances, Appeals and Contested Case Hearings

- (1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.
- (2) The CCO must establish and have an Authority approved process and written procedures, for the following:
 - (a) Member rights to appeal and request a CCO's review of an action;
 - (b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and
 - (c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

- (d) An explanation of how CCOs shall accept, process, and respond to appeals, hearing requests, and grievances;
 - (e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.
- (3) Upon receipt of a grievance or appeal, the CCO must:
- (a) Acknowledge receipt to the member;
 - (b) Give the grievance or appeal to staff with the authority to act upon the matter;
 - (c) Obtain documentation of all relevant facts concerning the issues;
 - (d) Ensure that staff making decisions on the grievance or appeal are:
 - (A) Not involved in any previous level of review or decision-making; and
 - (B) Health care professionals, as defined in OAR 410-120-0000, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.
- (4) The CCO must analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.
- (5) CCOs must keep all information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment, or CCO health care operations, are defined in 45 CFR 164.501.
- (6) The following pertains to release of a member's information:
- (a) The CCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use this information without the member's signed release for purposes of:
 - (A) Resolving the matter; or
 - (B) Maintaining the grievance or appeals log.
 - (b) If the CCO needs to communicate with other individuals or entities, not listed in subsection (a), to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.
- (7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:
- (a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;
 - (b) Free interpreter services;
 - (c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
 - (d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
- (8) The CCO and its participating providers may not:
- (a) Discourage a member from using any aspect of the grievance, appeal, or hearing process;
 - (b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
 - (c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
- (9) In all CCO administrative offices and in those physical, behavioral, and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must make the following forms available:
- (a) Grievance forms;
 - (b) Appeal forms;
 - (c) Hearing request forms (DHS 443); and
 - (d) Notice of hearing rights (DMAP 3030).

(10) A member's provider:

- (a) Acting on behalf of and with written consent of the member, may file an appeal;
- (b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests, and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

- (a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;
- (b) Monitor the subcontractor's performance on an ongoing basis;
- (c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
- (d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

- (a) The logs must contain the following information pertaining to each member's appeal or grievance:
 - (A) The member's name, ID number, and date the member filed the grievance or appeal;
 - (B) Documentation of the CCO's review, resolution, or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;
 - (C) Notations of oral and written communications with the member; and
 - (D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

- (A) The number of actions; and
- (B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

- (a) Life, health, mental health or dental health; or
- (b) Ability to attain, maintain or regain maximum function.

(16) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending.

(a) To be entitled to continuing benefits, the member must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

- (A) The tenth day following the date of the notice or the notice of appeal resolution; and
- (B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay caused by circumstances beyond the control of the member is not counted.

(c) The benefits must be continued until:

- (A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits, no later than ten days following the date of the notice of appeal resolution;
- (B) A final order resolves the contested case;
- (C) The time period or service limits of a previously authorized service have been met; or
- (D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3261

CCO Grievance Process Requirements

(1) A member may file a grievance:

(a) Orally or in writing; and

(b) With the Authority or the CCO. The Authority shall promptly send the grievance to the CCO.

(2) The CCO must resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:

(a) Within 5 working days from the date of receipt of the grievance; or

(b) If the CCO needs additional time to resolve the grievance, the CCO shall respond within 30 calendar days from the date of receipt of the grievance. If additional time is needed the CCO shall notify the member, within 5 working days, of the reasons additional time is necessary.

(3) When informing members of the CCO's decision the CCO:

(a) May provide its decision about oral grievances either orally or writing;

(b) Must address each aspect of the grievance and explain the reason for the decision; and

(c) Must respond in writing to written grievances. In addition to written responses, the CCO may also respond orally.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3262

Requirements for an Appeal to a CCO

(1) Members may appeal a CCO's notice of action. The following pertains to requests for appeal:

(a) The member must request the appeal within 45 days from the date on the notice of action;

(b) The member may make the request:

(A) Orally; or

(i) If a member makes an oral appeal request the CCO shall send the member an appeal request form and provide assistance in completing and filing the forms, if necessary.

(ii) Oral requests must be followed up with a written, signed and dated request unless the request is for an expedited appeal.

(iii) If the member makes an oral request for an expedited appeal the CCO must record the date of the oral appeal to establish the earliest possible date of request.

(B) In writing.

(2) The CCO must:

(a) Inform the member of the right to present evidence and review the documents;

(b) Provide the member a reasonable opportunity to present evidence of fact or law in person and in writing; and

(c) Provide the member with an opportunity before and during the appeal process to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

- (3) Parties to the appeal include the CCO, the member's provider, and the member.
- (4) The CCO must resolve each appeal and provide the member a notice of appeal resolution as expeditiously as the member's health condition requires but within the following timeframes:
 - (a) For standard resolution, no later than 16 calendar days from the date the CCO receives the appeal; and
 - (b) For expedited resolution, no later than three working days from the date the CCO receives the request for expedited appeal.
- (5) For expedited resolutions, the CCO must:
 - (a) Inform the member of the limited time available;
 - (b) Make reasonable efforts to call and inform the member of the three working day timeframe for an expedited resolution; and
 - (c) Mail written confirmation of the resolution to the member within three working days.
- (6) The Authority may extend the standard resolution timeframe and additional 14 calendar days if:
 - (a) The member requests the extension; or
 - (b) The CCO shows, to the Authority's satisfaction, that necessary information is unattainable for a 16 day resolution, and the delay is in the member's interest.
- (7) The CCO may request an extension. If the Authority approves the request, the CCO must give the member written notice of and the reason for the extension.
- (8) The CCO must provide written notice of appeal resolution to the member and the member's representative when the CCO knows there is a representative for the member. The notice must contain the same elements set forth in OAR 410-141-3263(Notice of Action).
- (9) If the member has not requested a hearing prior to the appeal resolution, the member may request a hearing no later than 45 calendar days from the date on the notice of appeal resolution.
- (10) If the Authority receives a request for hearing following a CCO appeal resolution, the CCO must provide the following to the Authority within two working days from the date of the appeal resolution:
 - (a) A copy of the notice of appeal resolution; and
 - (b) A copy of all documents related to the action and to the appeal resolution.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3263

Notice of Action

- (1) A CCO must provide a member with a notice of action when the CCO's decision about a health service constitutes an action. The notice of action must:
 - (a) Be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the action and requesting a hearing;
 - (b) Comply with the Authority's formatting and readability standards;
 - (c) The notice must include but is not limited to the following:
 - (A) Date of the notice;
 - (B) CCO's name and telephone number;
 - (C) Name of the member's PCP, PCD, or behavioral health professional, as applicable;
 - (D) Member's name and member ID number;
 - (E) Service requested and whether the CCO is denying, terminating, suspending or reducing a service or payment;
 - (F) Date of the service or date the member requested the service;
 - (G) Name of the provider who performed or requested the service;
 - (H) Effective date of the action if different from the date of the notice;

- (I) Whether the CCO considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;
 - (J) Clearly and thoroughly explain reasons for the action and a reference to the specific sections of the statutes and rules pertaining to each reason;
 - (K) Member's right to file an appeal with the CCO or request a contested case hearing;
 - (L) An explanation of circumstances under which the member may request expedited resolution of an appeal; and
 - (M) A statement that the member has the right to request to receive the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the CCO's action.
- (2) The CCO must attach the following forms to a notice:
- (a) Hearing request form (DHS 443); and
 - (b) Notice of hearing rights form (DMAP 3030).
- (3) For actions affecting previously authorized services, the CCO must mail the notice at least 10 calendar days before the date of action with the exception of circumstances described in section (4) of this rule.
- (4) The CCO may mail the notice no later than the date of action if:
- (a) The CCO or provider has information confirming the death of the member;
 - (b) The member sends the CCO a signed statement stating the member no longer wants the service;
 - (c) The CCO can verify that the member is in an institution where the member is no longer eligible for OHP services;
 - (d) The CCO is unaware of the member's whereabouts; the post office returns the mail indicating no forwarding address; and the Authority or Department of Human Services has no other address;
 - (e) The CCO verifies another state, territory, or commonwealth has accepted the member for Medicaid services;
 - (f) The member's PCP, PCD, or behavioral health professional has prescribed a change in the level of health services; or
 - (g) The date of action shall occur in less than 10 calendar days when the CCO:
 - (A) Has facts indicating probably fraud by the member, and the CCO has certified those facts, if possible, through a secondary resource; or
 - (B) Denies payment for a claim.
- (5) For actions affecting services not previously authorized, the CCO must send the notice as expeditiously as the member's health condition requires but no later than 14 calendar days following the date of receipt of the request for service.
- (6) For actions affecting services not previously authorized and for which the CCO grants expedited review, the CCO must send the notice as expeditiously as the member's health condition requires but no later than three business days after receipt of the request for service.
- (7) The following applies to an extension of the timeframes outlined in sections (5) and (6) of this rule:
- (a) The Authority may grant an additional 14 calendar days if:
 - (A) The member or the member's provider requests an extension; or
 - (B) The CCO requests an extension, because the CCO needs additional information and the extension is in the best interest of the member.
 - (b) If the Authority grants the extension, the CCO must:
 - (A) Give the member written notice of the reason for the decision to extend the timeframe;
 - (B) Inform the member of the right to file a grievance if they disagree with that decision.
- Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
- Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3264

Contested Case Hearings

- (1) A CCO must have a system in place to ensure its members and providers have access to appeal a CCO's action by requesting a contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700.
- (2) The member may request a hearing without first filing an appeal with their CCO. The member must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of action or notice of appeal resolution. If the member files the hearing request with the Department of Human Services or the CCO no later than 45 days from the date of the notice, the Authority shall consider the request timely.
- (3) In the event a request for hearing is not timely, the Authority shall determine whether the failure to timely file the hearing request was caused by circumstances beyond the member's control and enter an order accordingly. The member must submit a written statement explaining why the hearing request was late. The Authority may conduct further inquiry as the Authority deems appropriate. The Authority may refer an untimely request to the Office of Administrative Hearings (OAH) for a hearing on the question of timeliness;
- (4) The CCO must conduct an appeal if the member requests an appeal without filing a request for hearing. If the member requests a hearing, without first requesting an appeal, the Authority may require the CCO to conduct an appeal prior to referring the matter to OAH.
- (5) Effective February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in the division of rules in OAR 410 division 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to CCO hearing requests.
- (6) If the member files a request for hearing with the Authority, the Authority shall provide a copy of the hearing request to the member's CCO. The CCO shall:
 - (a) Review the request immediately as an appeal of the CCO's action;
 - (b) Approve or deny the appeal within 16 calendar days, and provide the member with a notice of appeal resolution.
- (7) If a member sends the hearing request to their CCO, the CCO must:
 - (a) Date-stamp the hearing request with the date of receipt; and
 - (b) Submit the following to the Authority within two business days:
 - (A) A copy of the hearing request, notice of action, and notice of appeal resolution, if applicable;
 - (B) All documents and records the CCO relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests.
- (8) A member's provider may request a hearing about an action affecting the provider. However, the provider must resolve an appeal with the CCO before requesting a hearing.
 - (a) The CCO must approve or deny the appeal within 16 calendar days, and provide the provider with a notice of appeal resolution.
 - (b) The provider must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of appeal resolution.
- (9) The parties to a contested case hearing include the:
 - (a) CCO and the member requesting a hearing; or
 - (b) CCO and the member's provider if the provider requests a hearing.
- (10) The Authority shall refer the hearing request along with the notice of action or notice of appeal resolution to OAH for hearing.

(11) The Authority must issue a final order or the Authority must resolve the case ordinarily within 90 calendar days from the earlier of the date:

(a) The CCO receives the member's request for appeal. This does not include the number of days the member took to subsequently file a hearing request; or

(b) The Authority receives the request for hearing.

(12) If a member requests an expedited hearing, the Authority shall request documentation from the CCO, and the CCO shall submit relevant documentation, including clinical documentation, to the Authority within two working days.

(13) The Authority must determine whether the member is entitled to an expedited hearing within two working days from the date of receipt of the medical documentation. If the Authority denies a request for an expedited hearing, the Authority must make reasonable efforts to:

(a) Call the member; and

(b) Send written notice within two calendar days.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3268

Process for Resolving Disputes on Formation of CCO

(1) The dispute resolution process described in this rule applies only when, under ORS 414.635:

(a) An entity is applying to the Authority for certification as a CCO (applicant);

(b) A health care entity (HCE) and the applicant (together, the "parties" for purposes of this rule) have failed to agree upon terms for a contract; and

(c) One or more of the following occurs:

(A) The applicant states that the HCE is necessary for the applicant to qualify as a CCO;

(B) An HCE states that its inclusion is necessary for the applicant to be certified as CCO; or

(C) In reviewing the applicant's information, the Authority identifies the HCE as necessary for the applicant to qualify as a CCO.

(2) If an applicant and HCE disagree about whether the HCE is necessary for the applicant's certification as a CCO, the applicant or HCE may request the Authority to review the issue.

(3) If the Authority determines the HCE is not necessary for the applicant's certification, the process described in this rule does not apply.

(4) If the Authority determines or the parties agree the HCE is necessary for the applicant's certification, the following applies:

(a) The HCE and the applicant shall participate in good faith contract negotiations. The parties must take the following actions in an attempt to reach a good faith resolution:

(A) The applicant must provide a written offer of terms and conditions to the HCE. The HCE must explain the area of disagreement to the applicant;

(B) The applicant's or HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or applicant must have at least one face-to-face meeting in a good faith effort to resolve the disagreement.

(b) The applicant or HCE may request the Authority to provide technical assistance. The Authority also may offer technical assistance, with or without a request. The Authority's technical assistance is limited to clarifying the CCO certification process, criteria, and other program requirements.

(5) If the applicant and HCE cannot reach agreement on contract terms within 10 calendar days of the face-to-face meeting, either party may request arbitration. The requesting party must notify the other party in writing to initiate referral to an independent third party arbitrator. The party initiating the referral must provide a copy of the notification to the Authority.

(6) After notification that one party initiated arbitration, the parties shall attempt to agree upon the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator.

(7) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay.

(8) Within 10 calendar days of a referral to an arbitrator, the applicant and HCE must submit to each other and to the arbitrator:

(a) Their most reasonable contract offer; or

(b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.

(9) Within ten calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party must submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.

(10) The arbitrator shall apply the following standards when making a determination about whether a HCE reasonably or unreasonably refused to contract with the applicant:

(a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers and tribal health centers; and

(b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the HST legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:

(A) Whether contracting with the applicant would impose demands that the HCE, taking into consideration the legislative policies described in the HST laws, cannot reasonably meet without significant negative impact on HCE costs, obligations or structure, in the context of the proposed reimbursement arrangement or other CCO requirements, including, but not limited to, the use of electronic health records, service delivery requirements or quality or performance requirements;

(B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant should make a good faith effort to work out differences in order to achieve beneficial community objectives and HST policy objectives;

(C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant, and that participation significantly reduces the HCE's capacity to contract with the applicant.

(11) The following outlines the arbitrator determination and the parties' final opportunity to settle:

(a) The arbitrator must evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;

(b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for 10 calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the 10th day, the arbitrator may not release the determination to the Authority;

(c) If the parties have not reached an agreement after 10 calendar days, the arbitrator must provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.

(12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:

- (a) The Authority may certify an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;
- (b) The Authority may refuse to certify, recertify or continue to certify an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from that the HCE remains necessary for certification of applicant as a CCO;
- (c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant; this applies to health services available through a CCO;
- (d) In any circumstance within the scope of this rule when the parties have failed to agree, the current statutes regarding reimbursement to non-participating providers shall apply to certified CCOs and the HCE, consistent with ORS 414.743 for hospitals, and consistent with Authority rules for other providers.

(13) To be qualified to resolve disputes under this rule, the arbitrator must:

- (a) Be a knowledgeable and experienced arbitrator;
- (b) Be familiar with health care provider contracting matters;
- (c) Be familiar with HST; and
- (d) Follow the terms and conditions specified in this rule for the arbitration process.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3270

Marketing Requirements

- (1) CCOs may not conduct, directly or indirectly, door-to-door, telephonic, electronic, mail or other cold call marketing practices to seek or influence the Medicaid client to enroll in that CCO.
- (2) CCOs may engage in activities to existing members for outreach, health promotion and health education.
- (3) The Authority must approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:
 - (a) Is intended solely for members; and
 - (b) Pertains to provider requirements for obtaining coordinated care services, care at service sites or benefits.
- (4) CCOs may communicate with providers, caseworkers, community agencies and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include, but are not limited to brochures, pamphlets, newsletters, posters, fliers, Web sites, health fairs or sponsorship of health-related events.
- (5) The creation of name recognition, because of the CCO's health promotion or education activities, shall not constitute an attempt by the CCO to influence a client's enrollment.
- (6) CCOs shall cooperate with the Authority in developing a comprehensive explanation of the services available from the CCO for the Division communications.
- (7) Subcontractors may post a sign listing all OHP CCOs to which the provider belongs and display CCO-sponsored health promotional materials.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3280

Potential Member Information Requirements

(1) CCOs shall develop informational materials for potential members:

(a) CCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. Upon request, the CCO must make available to potential members information on participating providers. The information must include participating providers' name, location, languages spoken other than English, qualification and the availability of the PCPs, clinic and specialists, prescription drug formularies used and whether they are currently accepting members. A CCO or the Authority may include informational materials in the application packet for potential members;

(b) CCOs shall ensure that all CCO staff who have contact with potential members are fully informed of the CCO's and the Authority's rules applicable to enrollment, disenrollment, complaint and grievance policies and interpreter services, including which participating providers' offices have bilingual capacity;

(c) Information for potential members must comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270.

(2) Informational materials that CCOs develop for potential members in its service area shall meet the language requirements of, and be culturally sensitive to, people with disabilities or reading limitations, including substantial populations whose primary language is not English:

(a) CCOs shall follow the Authority's household criteria required by ORS 411.970, which determines and identifies those populations considered to be non-English speaking households. The CCO shall provide informational materials, which at a minimum, shall include the member handbook in the primary language of each substantial population. Alternate formats shall be provided and may include but are not limited to audio tapes, close-captioned videos, large type, and Braille;

(b) CCOs shall write all written informational materials for potential members at the sixth grade reading level, using plain language standards, and printed in 12 point font or larger.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3300

Member Education Requirements

(1) CCOs shall have a mechanism to help members and potential members understand the requirements and benefits of the CCO's integrated and coordinated care plan.

(2) CCOs shall have written procedures, criteria and an ongoing process of member education and information sharing that includes member orientation, member handbook and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education must:

(a) Include information about the coordinated care approach, and how to navigate the coordinated health care system;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators.

(3) Within 14 calendar days of a CCO's receiving notice of a member's enrollment, CCOs shall mail an educational packet to new members and to members returning to the CCO nine months or more after previous enrollment. The packet shall include, at a minimum, a member handbook, provider directory and welcome letter.

(4) For members who are ongoing enrollees, a CCO shall offer the member handbook and provider directory annually and send on request. The CCO shall offer these in print and online if available.

(5) A CCO shall electronically provide to the Authority for approval each version of the printed member handbook and provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other languages spoken by substantial populations of members.

Substantial means 35 or more households that speak the same language and in which no adult speaks English. The tag lines must describe how members may access interpreter services, including sign interpreters, translations, and materials in other formats;

(c) CCO's office location, mailing address, Web address, if applicable, office hours and telephone numbers including TTY;

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

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

(f) What services the member may self-refer to either participating or non-participating providers;

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

(h) Explanation of intensive care coordination services (formerly known as Exceptional Needs Care Coordination (ENCC)) and how members with special health care needs, who are aged, blind or disabled, or who have complex medical needs, high health needs, multiple chronic conditions, mental illness or chemical dependency can access intensive care coordination services;

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

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

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

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

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

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member, as outlined in 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263.

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

(o) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care;

(p) Information about when providers may bill clients for services, and what to do if they receive a bill;

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

(r) Information on advance directive policies including:

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

- (B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.
- (s) Whether or not the CCO uses provider incentives to reduce cost by limiting services;
- (t) The member's right to request and obtain copies of their clinical records (and whether they may be charged a reasonable copying fee) and to request that the record be amended or corrected;
- (u) How and when members are to obtain ambulance services;
- (v) Resources for help with transportation to appointments with providers;
- (w) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;
- (x) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;
- (y) The CCO's confidentiality policy;
- (z) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;
- (aa) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;
- (bb) The CCO shall compile a printed provider directory and may offer the directory online, if available, for distribution to members, which may be part of their member handbook or separate, and shall include currently contracted provider names and specialty, non-English languages spoken, office location, telephone numbers including TTY, office hours, and accessibility for members with disabilities;
- (cc) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;
- (dd) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook and a CCO may not use it to substitute for any component of the CCO's member handbook.
- (6) Member health education shall include:
- (a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. A CCO's providers or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures;
- (b) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;
- (c) Explanation of intensive care coordination services, formerly known as ENCC and how to access intensive care coordination, through outreach to members with special health care needs, who are aged, blind or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness or chemical dependency;
- (d) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;
- (e) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the members' ability to access care or services from CCO's participating providers. The CCO shall provide the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30 day notice requirement. The Authority shall review and approve the materials within two working days.

(7) Informational materials that CCOs develop for members shall meet the language requirements of, and be culturally sensitive to, members with disabilities or reading limitations, including substantial populations whose primary language is not English:

(a) CCOs shall translate materials for substantial populations of non-English speaking members in the CCO's caseload. The CCO shall provide informational materials which shall include but not be limited to the member handbook in the primary language of each substantial population. Alternative forms may include, but are not limited to audio recordings, close-captioned videos, large type and Braille;

(b) Form correspondence sent to members, including but not limited to, enrollment information, choice and member counseling letters and notices of action to deny, reduce or stop a benefit shall include instructions in the language of each substantial population of non-English speaking members on how to receive an oral or written translation of the material.

(8) CCOs shall provide an identification card to members, unless waived by the Authority, which contains simple, readable and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3320

Coordinated Care Organization Member Rights and Responsibilities

(1) CCO members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

(b) Be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;

(c) Choose a Primary Care Provider (PCP) or service site, and to change those choices as permitted in the CCO's administrative policies;

(d) Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;

(e) Have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;

(f) Be actively involved in the development of their treatment plan;

(g) Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;

(h) Consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(i) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(j) Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

(k) Receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.

(l) Receive oversight, care coordination and transition and planning management from their CCO within the targeted population of AMH to ensure culturally and linguistically appropriate community-

based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.

- (m) Receive necessary and reasonable services to diagnose the presenting condition;
 - (n) Receive integrated person centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;
 - (o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;
 - (p) Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
 - (q) Obtain covered preventive services;
 - (r) Have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;
 - (s) Receive a referral to specialty providers for medically appropriate covered coordinated care services, in the manner provided in the CCO's referral policy;
 - (t) Have a clinical record maintained which documents conditions, services received, and referrals made;
 - (u) Have access to one's own clinical record, unless restricted by statute;
 - (v) Transfer of a copy of the clinical record to another provider;
 - (w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
 - (x) Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
 - (y) Be able to make a complaint or appeal with the CCO and receive a response;
 - (z) Request a contested case hearing;
 - (aa) Receive certified or qualified health care interpreter services; and
 - (bb) Receive a notice of an appointment cancellation in a timely manner.
- (2) CCO members shall have the following responsibilities:
- (a) Choose, or help with assignment to, a PCP or service site;
 - (b) Treat the CCO, provider, and clinic staff members with respect;
 - (c) Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if he/she expects to be late;
 - (d) Seek periodic health exams and preventive services from his/her PCP or clinic;
 - (e) Use his/her PCP or clinic for diagnostic and other care except in an emergency;
 - (f) Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
 - (g) Use urgent and emergency services appropriately, and notify the member's PCP or clinic within 72 hours of using emergency services, in the manner provided in the CCO's referral policy;
 - (h) Give accurate information for inclusion in the clinical record;
 - (i) Help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;
 - (j) Ask questions about conditions, treatments, and other issues related to his/her care that is not understood;
 - (k) Use information provided by CCO providers or care teams to make informed decisions about treatment before it is given;
 - (l) Help in the creation of a treatment plan with the provider;

- (m) Follow prescribed agreed upon treatment plans and actively engage in their health care;
- (n) Tell the provider that his/her health care is covered under the OHP before services are received and, if requested, to show the provider the Division Medical Care Identification form;
- (o) Tell the Department or Authority worker of a change of address or phone number;
- (p) Tell the Department or Authority worker if the member becomes pregnant and to notify the worker of the birth of the member's child;
- (q) Tell the Department or Authority worker if any family members move in or out of the household;
- (r) Tell the Department or Authority worker if there is any other insurance available;
- (s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
- (t) Pay the monthly OHP premium on time if so required;
- (u) Assist the CCO in pursuing any third party resources available and reimburse the CCO the amount of benefits it paid for an injury from any recovery received from that injury; and
- (v) Bring issues, or complaints or grievances to the attention of the CCO.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3340

Procedure for General Financial Reporting and for Determining Financial Solvency Matters

(1) The Authority shall determine financial solvency of a CCO in accordance with OAR 410-141-3345 through 410-141-3395, the request for applications and the CCO contract. In implementing OAR 410-141-3345 to 410-141-3395, the Authority may enter into a cooperative agreement with another state agency to carry out these provisions. For purposes of obtaining necessary information to determine financial solvency, any reference to OHA in these rules shall include DCBS when DCBS is working cooperatively with OHA to implement these provisions. However, only OHA may take enforcement action or other regulatory sanctions related to the implementation of OAR 410-141-3345 to 410-141-3395 and the CCO contract.

(2) OAR 410-141-3345 to 410-141-3395 are developed in consultation with DCBS in accordance with Section 13, chapter 602, Oregon Laws 2011 (Enrolled House Bill 3650) and Section 1, chapter 8, Oregon Laws 2012 (Enrolled Senate Bill 1580).

(3) Where these rules specify that the OHA may request or receive information or provide a response or take any action, DCBS may act on behalf of OHA. A response to DCBS under these rules shall be considered a response to the OHA on the matter, consistent with the objective of providing a single point of reporting by CCOs.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3345

General Financial Reporting and Financial Solvency Matters; CCO Reporting Method

(1) Each CCO must demonstrate that it is able to provide coordinated care services efficiently, effectively and economically. CCOs shall maintain sound financial management procedures, maintain protections against insolvency and generate periodic financial reports as provided in these rules.

(2) The Authority shall collaborate with DCBS to review CCO financial reports and evaluate financial solvency. Except as provided in this section, CCOs are not required to file financial reports with both OHA and DCBS:

(a) Initial applicants for certification as a CCO will submit all required information to OHA as part of the application process, and OHA will transmit that information to DCBS for its review. In making its determination about the qualifications of the applicant OHA will consult with DCBS about the financial materials and reports submitted with the application;

(b) For purposes of these financial reporting and solvency rules, DCBS is authorized to make recommendations to OHA and to act in conjunction with OHA in accordance with these rules. If quarterly reports or other evidence suggest that a CCO's financial solvency is in jeopardy, OHA will act as necessary to protect the public interest.

(3) OHA may address any proper inquiries to any CCO or its officers in relation to the activities or condition of the CCO or any other matter connected with its transactions. The person shall promptly and truthfully reply to the inquiries using the form of communication requested by OHA. The reply shall be timely, accurate and complete and, if OHA requires, verified by an officer of the CCO. A reply is subject to the provisions of ORS 731.260.

(4) OAR 410-141-3345 through 410-141-3395 provide for three alternative methods for a CCO's solvency plan and financial reporting requirements, depending on the status of the CCO as described in this rule:

(a) OHA reporting CCO: The CCO complies with restricted reserve and net worth requirements OHA used to regulate financial solvency of MCOs on July 1, 2012, submitting financial information and reports to OHA as detailed in the CCO contract. Under this approach, OHA will monitor the CCO's financial solvency utilizing the same reporting format and financial standards that OHA used for MCOs on July 1, 2012;

(b) DCBS reporting CCO: The CCO complies with financial requirements as detailed in the CCO contract and in OAR 410-141-3345 through 410-141-3395, including risk based capital and NAIC reporting requirements. These requirements will be monitored by DCBS;

(c) Certificate of Authority: The CCO has a certificate of authority and complies with financial reporting and solvency requirements applicable to licensed health entities pursuant to applicable DCBS requirements under the Oregon insurance code and DCBS rules. In addition, the CCO shall report to OHA the schedules outlined in the CCO contract.

(5) CCO Status. The method described in this rule that applies to a CCO is determined as follows:

(a) If the CCO is a licensed health entity, CCO shall use the method described in this rule for certificate of authority. The CCO shall submit a copy of its certificate of authority to OHA, not later than the readiness review document submission date under the initial CCO contract, and annually thereafter not later than August 31st. CCO shall report to OHA immediately at any time that this certificate of authority is suspended or terminated;

(b) If the CCO is neither a converting MCO nor a licensed health entity, the CCO shall use the method described in this rule for DCBS reporting CCO;

(c) If the CCO is a converting MCO and is not a licensed health entity, the CCO shall elect either the method described in this rule for OHA reporting CCO or the method described in this rule for DCBS reporting CCO. The CCO shall notify OHA of its election no later than the readiness review document submission date under the initial CCO contract. The CCO shall comply with the requirements applicable to its elected method until it notifies OHA of its intent to change its election. If the CCO expects to change its election, any elements of the solvency plan or solvency protection arrangements, the CCO shall provide written advance notice to OHA, at least 90 calendar days before the proposed effective date of change. Such changes are subject to written approval from OHA.

(6) CCOs may be required to use specific required reporting forms or items in order to supply information related to financial responsibility, financial solvency and financial management. The OHA or DCBS, as applicable, will provide supplemental instructions about the use of these forms.

(7) The standards established in OAR 410-141-3350 through 410-141-3395 are intended to be consistent with, and may utilize procedures and standards common to insurers and to DCBS in its

administration of financial reporting and solvency requirements. Any reference in these rules to the insurance code or to rules adopted by DCBS under the insurance code shall not be deemed to require a CCO to be an insurer, but is adopted and incorporated by reference as an OHA standard. Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3350

Assets, Liabilities, Reserves – DCBS REPORTING CCOs ONLY

- (1) The provisions of this rule apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.
- (2) In any determination of the financial condition of a CCO, there shall be allowed as assets only such assets as are owned by the CCO and which consist of:
 - (a) Cash in the possession or control of the CCO, including the true balance of any deposit in a solvent bank or trust company;
 - (b) Investments held in accordance with these rules, and due or accrued income items in connection therewith to the extent considered by the Authority to be collectible;
 - (c) Due premiums, deferred premiums, installment premiums, and written obligations taken for premiums, to the extent allowed by the Authority;
 - (d) The amount recoverable from a reinsurer if credit for reinsurance may be allowed to the CCO pursuant to OAR 410-141-3380;
 - (e) Deposits or equities recoverable from any suspended banking institution, to the extent deemed by the Authority to be available for the payment of losses and claims;
 - (f) Other assets considered by the Authority to be available for the payment of losses and claims, at values determined by the Authority.
- (3) In addition to assets impliedly excluded by this rule, the following expressly shall not be allowed as assets in any determination of the financial condition of a CCO:
 - (a) Advances to officers, employees, agents and other persons on personal security only;
 - (b) Stock of such CCO owned by it, or any material equity therein or loans secured thereby, or any material proportionate interest in such stock acquired or held through the ownership by such CCO of an interest in another firm, corporation or business unit;
 - (c) Tangible personal property, except such property as the CCO is otherwise permitted to acquire and retain as an investment under these rules and which is deemed by the Authority to be available for the payment of losses and claims or which is otherwise expressly allowable, in whole or in part, as an asset;
 - (d) The amount, if any, by which the book value of any investment as carried in the ledger assets of the CCO exceeds the value thereof as determined under these rules.
- (4) In any determination of the financial condition of a CCO, liabilities to be charged against its assets shall be calculated in accordance with these rules and shall include:
 - (a) The amount necessary to pay all of its unpaid losses and claims incurred on or prior to the date of the statement, whether reported or unreported to the CCO, together with the expenses of adjustment or settlement thereof;
 - (b) For insurance other than specified in Subsection (c) of this section, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, calculated in accordance with these rules;
 - (c) Reserves which place a sound value on its liabilities and which are not less than the reserves according to accepted actuarial standards consistently applied and based on actuarial assumptions relevant to contract provisions;
 - (d) Taxes, expenses and other obligations due or accrued at the date of the statement;

(e) Any additional reserves for asset valuation contingencies or loss contingencies required by these rules or considered to be necessary by the Authority for the protection of the Authority and the members of the CCO.

(5) If the Authority determines that a CCO's reserves, however calculated or estimated, are inadequate, the Authority shall require the CCO to maintain reserves in such additional amount as is needed to make them adequate.

(6) Funds of a CCO may be invested in a bond, debenture, note, warrant, certificate or other evidence of indebtedness that are not investment grade as established by these rules, but the funds that a CCO may invest under this section shall not exceed 20 percent of the CCO's assets. For purposes of this rule CCOs shall be subject to the requirements of OAR 836-033-0105 through 836-033-0130.

(7) A CCO shall not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the CCO's assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This subsection does not apply to:

(a) Investments in, or loans upon, the security of the general obligations of a sovereign; or

(b) Investments by a CCO in all real or personal property used exclusively by such CCO to provide health services or in real property used primarily for its home office.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3355

Restricted Reserves, Capital and Surplus– DCBS Reporting CCOs Only

(1) The provisions of OAR 410-141-3355 apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.

(2) A CCO shall:

(a) Establish a restricted reserve account; and

(b) Maintain adequate funds in this account to meet the Authority's primary and secondary restricted reserve requirements. Reserve funds are held for the purpose of making payments to providers in the event of the CCO's insolvency.

(3) A CCO shall establish a restricted reserve account with a third party financial institution for the purpose of holding the CCO's primary and secondary restricted reserve funds. CCOs shall use the model depository agreement to establish a restricted reserve account;

(a) A model depository agreement shall be used by the CCO to establish a restricted reserve account. CCOs shall request the model depository agreement form from the Authority. CCOs shall submit the model depository agreement to the Authority at the time of application and the model depository agreement shall remain in effect throughout the period of time that the CCO contract is in effect. The model depository agreement cannot be changed without the Authority's written authorization;

(b) The CCO shall not withdraw funds, change third party financial institutions, or change account numbers within the restricted reserve account without the written consent of the Authority;

(c) A CCO shall submit a copy of the model depository agreement at the time of application for certification. If a CCO requests and receives written authorization from the Authority to make a change to their existing restricted reserve account, the CCO shall submit a model depository agreement reflecting the changes to the Authority within 15 days of the date of the change;

(d) The following instruments are considered eligible deposits for the purposes of the Authority's primary and secondary restricted reserves:

(A) Cash;

(B) Certificates of Deposit; or

(C) Amply secured obligations of the United States, a state or a political subdivision thereof as determined by the Authority.

(e) In addition to the instruments allowed in this rule, a CCO may satisfy the primary restricted reserve amount by a surety bond that meets the requirements listed below:

(A) The bond is prepaid at the beginning of the contract year for 18 months;

(B) Evidence of prepayment is provided to the Authority;

(C) The surety bond is purchased by a surety bond company approved by the Oregon Insurance Division;

(D) The surety bond agreement contains a clause stating the payment of the bond will be made to the third party entity holding the restricted reserve account on behalf of the contracting company for deposit into the restricted reserve account;

(E) The surety bond agreement contains a clause that no changes to the surety bond agreement will occur until approved by the Authority; and

(F) The Authority approves the terms of the surety bond agreement.

(4) A CCO's primary and secondary reserve balances are determined by calculating the average monthly medical expense incurred. A CCO that has submitted quarterly financial statements for the current quarter and the prior three quarters, the average monthly medical expense incurred is derived by adding together the "total hospital and medical" expense (NAIC statement of revenue and expenses) for the prior four quarters and dividing by 12. A newly formed CCO will use an average of hospital and medical expense projected for the first four quarters of operation. Each quarter the average expense liability will be recalculated using historical quarter data available. The amount a CCO must deposit into the restricted reserve account shall be:

(a) If a CCO's average monthly medical expense incurred is less than or equal to \$250,000, an amount equal to the average monthly medical expense incurred. This amount will be referred to as the CCO's primary reserve and the CCO shall have no secondary reserve, until such time as the average monthly medical expense exceeds \$250,000;

(b) If a CCO's average monthly medical expense is greater than \$250,000, funds equaling 50 percent of the difference between the average monthly medical expense and the primary reserve balance of \$250,000. This amount will be referred to as the CCO's secondary reserve;

(c) Adjusted each quarter after the CCO calculates its average monthly medical expense each quarter.

(5) Working capital or surplus requirements:

(a) As used in this section, "net healthcare revenue" means direct healthcare premium less the following: amounts paid for reinsurance ceded, HRA and GME payments (if any received by a CCO), and MCO taxes. "Net healthcare revenue" includes all healthcare related revenue and fee-for-service revenue adjusted for the change in unearned premium reserves;

(b) Except as provided in Section (8) CCOs shall possess and thereafter maintain capital or surplus, or any combination thereof, equal to the greater of \$2.5 million or the amount required from the application of the risk-based capital standards in OAR 410-141-3360;

(c) A CCO that possesses the amount required in this rule as of the effective date of this rule must thereafter maintain that capital and surplus;

(d) Except as provided in Section (8), if a CCO does not possess the minimum capital and surplus as of the effective date of these rules, the CCO shall possess and thereafter maintain capital or surplus, or any combination thereof as follows:

(A) Five percent of annualized total net healthcare revenue as of August 1, 2012. The CCO shall calculate its authorized control level and file the RBC report in accordance with these rules;

(B) The greater of five percent annualized total net healthcare revenue or its authorized control level risk-based capital as of January 1, 2014;

(C) The greater of six percent of annualized total net healthcare revenue or 125 percent of its authorized control level risk-based capital as of January 1, 2015;

- (D) The greater of seven percent of annualized total net healthcare revenue or 150 percent of its authorized control level risk-based capital as of January 1, 2016;
 - (E) The greater of eight percent of annualized total net healthcare revenue or 175 percent of its authorized control level risk-based capital as of January 1, 2017;
 - (F) The greater of nine percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2018;
 - (G) The greater of 10 percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2019.
 - (e) A CCO may use a subordinated surplus note to meet its minimum capital and surplus requirement provided it meets the standards in Statements of Statutory Accounting Principles #41 and the Authority has given prior approval of the form and content of the surplus note;
 - (f) A converting CCO will initially be subject to financial responsibility and solvency standards applicable to an the Authority reporting CCO. Effective January 1, 2014, the converting CCO shall comply with the minimum capital and surplus set forth in this rule;
 - (g) The converting CCO shall calculate its authorized control level and file the RBC report in accordance with this rule.
 - (6) Funds of a CCO at least equal to its required capital and surplus shall be invested and kept invested as follows:
 - (a) In amply secured obligations of the United States, a state or a political subdivision of this state;
 - (b) In loans secured by first liens upon improved, unencumbered real property (other than leaseholds) in this state where:
 - (A) The lien does not exceed 50 percent of the appraised value of the property and the loan is for a term of five years or less;
 - (B) The lien does not exceed 66-2/3 percent of the appraised value of the property provided there is an amortization plan mortgage, deed of trust or other instrument under the terms of which the installment payments are sufficient to repay the loan within a period of not more than 25 years; or
 - (C) The investment is insured or guaranteed by the Federal Housing Administration, the United States Department of Veterans Affairs, or under Title I of the Housing Act of 1949 (providing for slum clearance and redevelopment projects) enacted by Congress on July 15, 1949.
 - (c) In deposits, certificates of deposit, accounts or savings or certificate shares or accounts of or in banks, trust companies, savings and loan associations or building and loan associations to the extent such investments are insured by the Federal Deposit Insurance Corporation.
 - (7) Investments made pursuant to Section (6) of this rule shall be kept free of any lien or pledge.
 - (8) A CCO that is not a converting CCO shall possess \$500,000 working capital above the minimum capital and surplus requirement upon the CCO contract date sufficient to pay initial expenses without causing the CCO to fall below the minimum capital and surplus required by these rules.
- Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3360

Risk-based capital – DCBS Reporting CCOs Only

- (1) The provisions of OAR 410-141-3360 shall apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.
- (2) As used in this rule:
 - (a) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;
 - (b) "Company Action Level RBC" means, with respect to any CCO, the product of 2.0 and the CCO's Authorized Control Level RBC;

- (c) "Mandatory Control Level RBC" means the product of .70 and the CCO's authorized control level RBC;
- (d) "RBC Instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;
- (e) "RBC Level" means a CCO's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC;
- (f) "RBC Plan" means a comprehensive financial plan containing the elements specified in this rule. If OHA rejects the RBC plan and it is revised by the CCO with or without OHA's recommendation, the plan shall be called the "revised RBC plan;"
- (g) "RBC Report" means the report required in OAR 410-141-3360;
- (h) "Regulatory Action Level RBC" means the product of 1.5 and the CCO's authorized control level RBC;
- (i) "Total Adjusted Capital" means the sum of:
- (A) A CCO's capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under these rules; and
 - (B) Such other items, if any, as the RBC instructions may provide.
- (3) For the purpose of determining the reasonableness and adequacy of a CCO's capital and surplus, the Oregon Health Authority must consider at least the following factors, as applicable:
- (a) The size of the CCO, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;
 - (b) The number of lives insured;
 - (c) The extent of the geographical dispersion of the lives insured by the CCO;
 - (d) The nature and extent of the reinsurance program of the CCO;
 - (e) The quality, diversification and liquidity of the investment portfolio of the CCO;
 - (f) The recent past and projected future trend in the size of the investment portfolio of the CCO;
 - (g) The combined capital and surplus maintained by comparable CCOs;
 - (h) The adequacy of the reserves of the CCO;
 - (i) The quality and liquidity of investments in affiliates. OHA may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of OHA the investment so warrants; and
 - (j) The quality of the earnings of the CCO and the extent to which the reported earnings include extraordinary items.
- (4) The following pertain to a CCO's RBC levels:
- (a) On or before March 1 of each year, a CCO shall prepare and submit to OHA a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a CCO shall file its RBC report with the NAIC in accordance with the RBC instructions. The CCO shall report in its annual financial statement the authorized control level calculated using its RBC report. A CCO's RBC report will be considered confidential under OAR 410-141-3390;
 - (b) A CCO's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:
 - (A) Asset risk;
 - (B) Credit risk;
 - (C) Underwriting risk; and
 - (D) All other business risks and such other relevant risks as are set forth in the RBC instructions.
 - (c) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in this rule and the formulas, schedules and instructions referenced in this

rule is desirable in the business of a CCO. Accordingly, CCOs should seek to maintain capital above the RBC levels required by this rule. Additional capital is used and useful in the business of a risk-bearing entity and helps to secure a CCO against various risks inherent in, or affecting, the business of a CCO and not accounted for or only partially measured by the risk-based capital requirements contained in this rule;

(d) If a CCO files an RBC report that in the judgment of OHA is inaccurate, then OHA shall adjust the RBC report to correct the inaccuracy and shall notify the CCO of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

(5) "Company Action Level Event" means any of the following events:

(a) The filing of an RBC report by a CCO that indicates that the CCO's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(b) If a CCO has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(c) Notification by OHA to the CCO of an adjusted RBC report that indicates an event in Section 15 of this section, if the CCO does not challenge the adjusted RBC report in this rule; or

(d) If a CCO challenges an adjusted RBC report that indicates the event in Section (5)(a), the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.

(6) In the event of a company action level event, the CCO shall prepare and submit to OHA an RBC plan that shall:

(a) Identify the conditions that contribute to the company action level event;

(b) Contain proposals of corrective actions that the CCO intends to take and that would be expected to result in the elimination of the company action level event;

(c) Provide projections of the CCO's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the CCO's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the CCO's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(7) The RBC plan shall be submitted:

(a) Within 45 days of the Company Action Level Event; or

(b) Within 45 days after notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO challenges an adjusted RBC report;

(c) Within 60 days after the submission by a CCO of an RBC plan to OHA, OHA shall notify the CCO whether the RBC plan shall be implemented or is, in the judgment of OHA, unsatisfactory. If OHA determines the RBC plan is unsatisfactory, the notification to the CCO shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory, in the judgment of OHA. Upon notification from OHA, the CCO shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by OHA, and shall submit the revised RBC plan to OHA:

(A) Within 45 days after the notification from OHA; or

(B) Within 45 days after a notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO challenges the notification from OHA under this rule.

(8) In the event of a notification by OHA to a CCO that the CCO's RBC plan or revised RBC plan is unsatisfactory, OHA may at OHA's discretion, subject to the CCO's right to a hearing under this rule, specify in the notification that the notification constitutes a regulatory action level event.

(9) "Regulatory Action Level Event" means, with respect to a CCO, any of the following events:

(a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) Notification by OHA to a CCO of an adjusted RBC report that indicates the event in Section (9)(a), if the CCO does not challenge the adjusted RBC report in this rule;

(c) If the CCO challenges an adjusted RBC report that indicates the event in this rule, the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;

(d) The failure of the CCO to file an RBC report by the filing date, unless the CCO has provided an explanation for the failure that is satisfactory to OHA and has cured the failure within ten days after the filing date;

(e) The failure of the CCO to submit an RBC plan to OHA within the time period set forth in this rule;

(f) Notification by OHA to the CCO that:

(A) The RBC plan or revised RBC plan submitted by the CCO is, in the judgment of OHA, unsatisfactory; and

(B) Notification constitutes a regulatory action level event with respect to the CCO, if the CCO has not challenged the determination in this rule.

(g) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge;

(h) Notification by OHA to the CCO that the CCO has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and OHA has so stated in the notification, if the CCO has not challenged the determination; or

(i) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge.

(10) In the event of a regulatory action level event OHA shall:

(a) Require the CCO to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as OHA deems necessary of the assets, liabilities and operations of the CCO including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as OHA shall determine are required (a "corrective order").

(11) In determining corrective actions, OHA may take into account factors OHA deems relevant with respect to the CCO based upon OHA's examination or analysis of the assets, liabilities and operations of the CCO, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within 45 days after the occurrence of the regulatory action level event;

(b) Within 45 days after the notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge; if the CCO challenges an adjusted RBC report, and the challenge is not frivolous in the judgment of OHA; or

(c) Within 45 days after the notification to the CCO that the care service CCO has, after a hearing, rejected the CCO's challenge, if the CCO challenges a revised RBC plan, and the challenge is not frivolous in the judgment of OHA.

(12) OHA may retain actuaries and investment experts and other consultants as may be necessary in the judgment of OHA to review the CCO's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the CCO and formulate the corrective order with respect to the CCO. The fees, costs and expenses relating to consultants shall be borne by the affected CCO or such other party as directed by OHA.

(13) "Authorized Control Level Event" means any of the following events:

- (a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;
- (b) The notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report;
- (c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;
- (d) The failure of the CCO to respond, in a manner satisfactory to OHA, to a corrective order if the CCO has not challenged the corrective order; or
- (e) If the CCO has challenged a corrective order in this rule and OHA has, after a hearing, rejected the challenge or modified the corrective order, the failure of the CCO to respond, in a manner satisfactory to OHA, to the corrective order subsequent to rejection or modification by OHA.
- (14) In the event of an authorized control level event with respect to a CCO, OHA shall:
- (a) Take such actions as are required by this rule regarding a CCO with respect to which an regulatory action level event has occurred; or
- (b) If OHA deems it to be in the best interests of the members and creditors of the CCO and of the public, take such actions as are necessary to work with the Authority, which may terminate the CCO contract and revoke or suspend its certification as a CCO.
- (15) "Mandatory Control Level Event" means any of the following events:
- (a) The filing of an RBC report that indicates that the CCO's total adjusted capital is less than its mandatory control level RBC;
- (b) Notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report; or
- (c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.
- (16) In the event of a mandatory control level event, OHA shall take such actions as are necessary to work with the Authority, which may terminate the CCO contract and revoke or suspend its certification as a CCO. Notwithstanding the provisions of this rule, OHA may forego action for up to 90 days after the mandatory control level event if OHA finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.
- (17) Upon the occurrence of any of the following events, a CCO may request a hearing for the purpose of challenging any determination or action by OHA in connection with any event described in this rule. The CCO shall notify OHA of its request for a hearing not later than the fifth day after notification by OHA under any of the events described in this rule. Upon receipt of the CCO's request for a hearing, OHA shall set a date for the hearing. The date shall be not less than 10 or more than 30 days after the date of the CCO's request. The events to which the opportunity for a hearing under this rule relates are as follows:
- (a) Notification to a CCO by OHA of an adjusted RBC report;
- (b) Notification to a CCO by OHA that:
- (A) The CCO's RBC plan or revised RBC plan is unsatisfactory; and
- (B) Notification constitutes a Regulatory Action Level Event with respect to the CCO.
- (c) Notification to a CCO by OHA that the CCO has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event with respect to the CCO in accordance with its RBC plan or revised RBC plan; or
- (d) Notification to a CCO by OHA of a corrective order with respect to the CCO.
- (18) OHA may keep confidential a CCO's RBC plan or the results or report of any examination or analysis conducted in this rule if OHA determines that disclosure of such information would jeopardize the CCO's corrective action plan.

(19) This rule shall not preclude or limit any other powers or duties of OHA or OHA under other laws and rules.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3365

Financial Reporting– DCBS Reporting CCOs Only

(1) The provisions of OAR 410-141-3365 shall apply only to DCBS reporting CCOs and do not apply to OHA reporting CCOs.

(2) Every CCO shall file with DCBS, on or before March 1 of each year, a financial statement for the year ending December 31 immediately preceding. The CCO shall also file with DCBS, on or before May 15, August 15, and November 15 of each year, quarterly financial statements for the quarter ending March 31, June 30 and September 30, respectively. All financial statements shall be completed in accordance with NAIC annual statement instructions. OHA may also require additional filings as OHA determines necessary.

(3) The financial statement filed by a CCO under this rule shall be verified by the oaths of the president and secretary of the CCO or, in their absence, by two other principal officers.

(4) Each CCO shall have an annual audit conducted by an independent certified public accountant and shall file an audited financial report annually with DCBS. The annual audited financial report shall be in the form required of insurers by the insurance code, specifically ORS 731.488 and OAR 836-011-0100 through 836-011-0220.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3370

Solvency Monitoring and Corrective Actions

(1) For purposes of this rule, the CCO shall be monitored in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under DCBS standards.

(2) OHA shall examine every CCO, including an audit of the financial affairs of such CCO, as often as OHA determines an examination to be necessary but generally at least once during the CCO's certification period. An examination shall be conducted for the purpose of determining the financial condition of the CCO, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with these rules and applicable CCO contract requirements.

(3) The following apply to CCO examinations:

(a) When OHA determines that an examination should be conducted, OHA shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the NAIC. OHA may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that OHA determines to be appropriate, taking into account whether the CCO is an OHA reporting CCO, is a DCBS reporting CCO, or has a certificate of authority;

(b) When making an examination, OHA may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed. The cost of retaining such professionals and specialists shall be borne by the CCO that is the subject of the examination;

(c) At any time during the course of an examination, OHA may take other action pursuant to these rules;

(d) Facts determined and conclusions made pursuant to an examination shall be presumptive evidence of the relevant facts and conclusions in any judicial or administrative action;

(e) Upon an examination or investigation OHA may examine under oath all persons who may have material information regarding the property or business of the person being examined or investigated;

(f) Every person being examined or investigated shall produce all books, records, accounts, papers, documents and computer and other recordings in its possession or control relating to the matter under examination or investigation, including, in the case of an examination, the property, assets, business and affairs of the person; and

(g) The officers, directors and agents of the person being examined shall provide timely, convenient and free access at all reasonable hours at the offices of the person being examined to all books, records, accounts, papers, documents and computer and other recordings. The officers, directors, employees and agents of the person must facilitate the examination.

(4) The following apply to the Authority's report following the examination:

(a) Not later than the 60th day after completion of an examination, the examiner in charge of the examination shall submit to OHA a full and true report of the examination, verified by the oath of the examiner. The report shall comprise only facts appearing upon the books, papers, records, accounts, documents or computer and other recordings of the person, its agents or other persons being examined or facts ascertained from testimony of individuals concerning the affairs of such person, together with such conclusions and recommendations as reasonably may be warranted from such facts;

(b) OHA shall make a copy of the report submitted under this section available to the person who is the subject of the examination and shall give the person an opportunity to review and comment on the report. OHA may request additional information or meet with the person for the purpose of resolving questions or obtaining additional information, and may direct the examiner to consider the additional information for inclusion in the report;

(c) Before OHA files the examination report as a final examination report or makes the report or any matters relating thereto public, the person being examined shall have an opportunity for a hearing. A copy of the report must be mailed by certified mail to the person being examined. The person may request a hearing not later than the 30th day after the date on which the report was mailed. This subsection does not limit the authority of OHA to disclose a preliminary or final examination report as otherwise provided in this section, or to CMS or other federal or state authorities authorized to obtain access to CCO financial records in accordance with the CCO contract;

(d) OHA shall consider comments presented at a hearing requested under paragraph (c) of this section and may direct the examiner to consider the comments or direct that the comments be included in documentation relating to the report, although not as part of the report itself. OHA may file the report as a final examination report at any time after consideration of the comments or at any time after the period for requesting a hearing has passed if a hearing is not requested;

(e) A report filed as a final examination report is subject to public inspection. OHA, after filing any report, if OHA considers it for the interest of the public to do so, may publish any report or the result of any examination as contained therein in one or more newspapers of the state without expense to the person examined; and

(f) OHA may disclose the content of an examination report that has not yet otherwise been disclosed or may disclose any of the materials described in this section as provided in OAR 410-141-3390.

(5) No cause of action may arise and no liability may be imposed against OHA or DCBS, an authorized representative of OHA or DCBS or any examiner appointed by OHA or DCBS for any statements made or conduct performed in good faith pursuant to an examination or investigation. No cause of action may arise and no liability may be imposed against any person for communicating or delivering information or data to OHA or an authorized representative of OHA or examiner pursuant to

an examination or investigation if the communication or delivery was performed in good faith and without fraudulent intent or intent to deceive.

(6) Section (5) does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by any person to which this subsection applies.

(7) Any CCO or applicant for CCO certification examined under this rule shall pay to OHA the just and legitimate costs of the examination as determined by OHA, including actual necessary transportation and traveling expenses.

(8) In addition to other powers of OHA under these rules relating to the examination and investigation of CCOs, OHA may also order any CCO to produce such books, records, accounts, papers, documents and computer and other recordings in the possession of the CCO or its affiliates as are necessary to ascertain the financial condition of the CCO or to determine compliance with these rules. If the CCO fails to comply with such an order, OHA may examine the affiliates to obtain such information, in addition to imposing sanctions or other remedies under these OHA rules or the CCO contract. A CCO shall pay the costs of an examination of the CCO.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3375 Hazardous Operations

(1) For purposes of this rule, the CCO will be held financially responsible in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under the DCBS standards:

(a) Based upon standards established by these rules, if OHA determines that the continued operation of a CCO is hazardous to its members or to the public in general, OHA may order the CCO to take one or more of the following actions:

(A) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(B) Reduce, suspend or limit the volume of business being accepted or renewed;

(C) Reduce general insurance and commission expenses by methods specified by OHA;

(D) Increase the capital and surplus of the CCO;

(E) Suspend or limit the declaration and payment of dividends by the CCO to its stockholders or members;

(F) Limit or withdraw from certain investments or discontinue certain investment practices to the extent OHA determines such action to be necessary.

(b) OHA may exercise authority under Subsection (a) of this section in addition to or instead of any other authority that OHA may exercise under these rules;

(c) OHA may issue an order with or without a hearing. A CCO subject to an order issued without a hearing may file a written request for a hearing to review the order. Such a request shall not stay the effect of the order. The hearing shall be held within 30 days after the filing of the request. OHA shall complete the review within 30 days after the record for the hearing is closed, and shall discontinue the action taken if OHA determines that none of the conditions giving rise to the action exists.

(2) OHA may consider the following standards, either singly or in combination of two or more, to determine whether the continued operation of any CCO might be determined to be hazardous to the CCO's members, its creditors or the general public:

(a) Adverse findings reported in financial condition examination reports, audit reports, and actuarial opinions, reports or summaries;

(b) Whether the CCO has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the CCO, when considered in light of the assets held by the CCO with respect to

- such reserves and related actuarial items including but not limited the investment earnings on such assets, and the considerations anticipated to be received and retained under such contracts;
- (c) The ability of an assuming reinsurer to perform and whether the CCO's reinsurance program provides sufficient protection for the CCO's remaining capital and surplus after taking into account the CCO's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;
 - (d) Whether the CCO's operating loss in the last 12-month period or any shorter period of time is greater than 50 percent of the CCO's remaining capital and surplus in excess of the minimum required;
 - (e) Whether the CCO's operating loss in the last 12-month period or any shorter period of time, excluding net capital gains, is greater than 20 percent of the CCO's remaining surplus in excess of the minimum required;
 - (f) Whether a reinsurer or obligor, or any entity within the CCO's system is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations and which, in the opinion of OHA may affect the solvency of the CCO;
 - (g) Contingent liabilities, pledges or guaranties that either individually or collectively involves a total amount that in the opinion of OHA may affect the solvency of the CCO;
 - (h) Whether any "controlling person" of a CCO is delinquent in the transmitting to, or payment of, net premiums to the CCO;
 - (i) The age and collectability of receivables;
 - (j) Whether the management of a CCO, including officers, directors or any other person who directly or indirectly controls the operation of the CCO, fails to possess and demonstrate the competence, fitness and reputation determined by OHA to be necessary to serve the CCO in such position;
 - (k) Whether management of a CCO has failed to respond to inquiries relating to the condition of the CCO or has furnished false and misleading information concerning an inquiry;
 - (l) Whether the CCO has failed to meet financial responsibility, accountability or filing requirements in the absence of a reason satisfactory to OHA;
 - (m) Whether management of a CCO either has filed a false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the CCO;
 - (n) Whether the CCO has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;
 - (o) Whether the CCO has experienced or will experience in the foreseeable future cash flow or liquidity problems, or both;
 - (p) Whether management has established reserves that do not comply with minimum standards established by the CCO contract or regulations, accounting standards, sound actuarial principles and standards of practice;
 - (q) Whether management persistently engages in material under reserving that results in adverse development;
 - (r) Whether transactions among affiliates, subsidiaries or controlling persons for which the CCO receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the CCO's ability to meet its outstanding obligations as they mature; and
 - (s) Any other finding determined by OHA to be hazardous to the CCO's members, creditors or general public.
- (3) For the purposes of making a determination of the financial condition of a CCO under these rules or the CCO contract, OHA may do one or more of the following:
- (a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

- (b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates;
 - (c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or
 - (d) Increase the CCO's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the CCO will be called upon to meet the obligation undertaken within the next 12-month period.
- (4) In addition to the requirements OHA may impose, if OHA determines that the continued operation of the CCO may be hazardous to OHA, the members or the general public, OHA may require the CCO to:
- (a) File reports in a form acceptable to OHA concerning the market value of the CCO's assets;
 - (b) In addition to regular annual statements, file interim financial reports on the form specified by OHA;
 - (c) Correct corporate governance practice deficiencies, and adopt and utilize the governance practices acceptable to OHA; or
 - (d) Provide a business plan to OHA demonstrating corrective action the CCO will take to improve its financial condition.
- (5) No CCO shall reduce its combined capital and surplus by partial distribution of its assets, by payment in the form of a dividend to stockholders or otherwise, below:
- (a) Its required capitalization; or
 - (b) A greater amount which OHA, by rule or by order after hearing upon the motion of OHA or the petition of any interested person, finds necessary to avoid injury or prejudice to the interest of OHA, members or creditors.
- (6) Whenever OHA determines from any showing or statement made to OHA or from any examination made by OHA that the assets of a CCO are less than its liabilities plus required capitalization, OHA may proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO, or OHA may allow the CCO a period of time, not to exceed 90 days, in which to make correct the amount of the impairment with cash or authorized investments. If the amount of any such impairment is not corrected within the time prescribed by OHA, OHA shall proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO.
- Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3380

Disallowance of Transactions – DCBS Reporting CCOs Only

- (1) The provisions of OAR 410-141-3380 apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.
- (2) OHA shall disallow as an asset or as a credit against liabilities any reinsurance found by OHA after a hearing thereon to have been arranged for the purpose principally of deception as to the ceding CCO's financial condition as of the date of any financial statement of the CCO. Without limiting the general purport of the foregoing provision, reinsurance of any substantial part of the CCO's outstanding risks contracted for in fact within four months prior to the date of any such financial statement and canceled in fact within four months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or substantial risk of net loss to itself, shall prima facie be deemed to have been arranged for the purpose principally of deception.
- (3) OHA shall disallow as an asset any deposit, funds or other assets of the CCO found by OHA after a hearing thereon:
 - (a) Not to be in good faith the property of the CCO;

- (b) Not freely subject to withdrawal or liquidation by the CCO at any time for the payment or discharge of claims or other obligations arising under its policies; and
- (c) To be resulting from arrangements made principally for the purpose of deception as to the CCO's financial condition as of the date of any financial statement of the CCO.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3385 Holding Company

(1) As used in this rule, "Holding Company System" as it applies to a CCO means two or more affiliated persons, one or more of which is a CCO, and includes a financial holding company as referred to in section 103 of the federal Gramm-Leach-Bliley Act (P.L. 106-102). Such CCO shall also be subject to OAR 836-027-0001 through 836-027-0050 to the extent those rules relate to the filing of a registration statement (Form B filing).

(2) Every CCO that is a member of a holding company system shall be subject to ORS 732.551 to 732.572, except ORS 732.554.

(3) A transaction within a holding company system to which a CCO subject to registration is a party is subject to the following standards:

(a) The terms must be fair and reasonable;

(b) Charges or fees for services performed must be reasonable;

(c) Expenses incurred and payment received must be allocated to the CCO in conformity with customary insurance accounting practices consistently applied;

(d) The books, accounts and records of each party to the transaction must be so maintained as to disclose clearly and accurately the nature and details of the transaction, including accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(e) The combined capital and surplus of the CCO following any transaction with an affiliate or any shareholder dividend must be reasonable in relation to the CCO's outstanding liabilities and adequate to its financial needs.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3390

Transparency

(1) Pursuant to ORS 414.018, interactions between OHA or DCBS and CCOs shall be done in a transparent and public manner. Without limitation of the preceding sentence, OHA or DCBS shall publicly disclose all information pertaining to CCOs of a character that DCBS publicly discloses pertaining to CCOs that are licensed health entities.

(2) Certain documents pertaining to a CCO's financial condition may be considered confidential, when so described in these rules. financial analysis solvency tools and analytical reports developed by the NAIC, and comparable reports developed or used by DCBS or OHA, are confidential. In addition, any work papers, recorded information, documents and copies thereof that are produced or obtained by or disclosed to OHA or DCBS, or any other person in the course of an examination or in the course of analysis by OHA or DCBS of the financial condition or market conduct of a CCO may be considered confidential, if the CCO specifically designates the confidential portions and cites an exemption from public disclosure under the Oregon Public Records Law, ORS 192.410 to 192.505. If OHA, in its sole discretion, determines that the cited exemption does not apply or disclosure is necessary to protect

the public interest, OHA may make available work papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to OHA or any other person in the course of the examination.

(3) The OHA or DCBS may use a confidential document, material or other information in administering these rules and in furthering a regulatory or legal action brought as a part of the OHA's duties. In order to assist in the performance of OHA's duties, OHA may:

(a) Authorize sharing a confidential document, material or other information as appropriate among the administrative divisions and staff offices of the OHA or DCBS for the purpose of administering and enforcing the statutes within the authority of OHA, in order to enable the administrative divisions and staff offices to carry out their functions and responsibilities;

(b) Share a document, material or other information, including a confidential document, material or other information that is subject to this rule or that is otherwise exempt from disclosure under ORS 192.501 or ORS 192.502, with other state, federal, foreign and international regulatory and law enforcement agencies and with the NAIC and affiliates or subsidiaries of the NAIC, if the recipient agrees to maintain the confidentiality of the document, material or other information; and

(c) Receive a document, material or other information, including an otherwise confidential document, material or other information, from state, federal, foreign and international regulatory and law enforcement agencies and from the NAIC and affiliates or subsidiaries of the NAIC. As provided in this section, the OHA shall maintain the confidentiality of documents, materials or other information received upon notice or with an understanding that the document, material or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(4) Disclosing a document, material or other information to the OHA, sharing a document, material or other information does not waive an applicable privilege or claim of confidentiality in the document, material or other information.

(5) OHA may release a final, adjudicated action, including a suspension or revocation of a CCO's certification, if the action is otherwise open to public inspection, to a database or other clearinghouse service maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(6) All information, documents and copies thereof obtained by or disclosed to OHA, DCBS or any other person in the course of an examination or investigation made pursuant to OAR 410-141-3365 are subject to the provisions of ORS 731.312.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

410-141-3395

Member Protection Provisions

(1) In the event of a finding of impairment by OHA or of a termination of certification as a CCO or of the CCO contract, members of the CCO shall be offered disenrollment from the CCO and enrollment in accordance with OHA rule.

(2) For the purpose of this section only, and only in the event of a finding of impairment by OHA or of a termination of certification or of the CCO contract, any covered health care service furnished within the state by a provider to a member of a CCO shall be considered to have been furnished pursuant to a contract between the provider and the CCO with whom the member was enrolled when the services were furnished.

(3) Each contract between a CCO and a provider of health services shall provide that if the CCO fails to pay for covered health services as set forth in the contract, the member is not liable to the provider for any amounts owed by the CCO.

(4) If the contract between the contracting provider and the CCO has not been reduced to writing or fails to contain the provisions required by this rule, the member is not liable to the contracting provider for any amounts owed by the CCO.

(5) No contracting provider or agent, trustee or assignee of the contracting provider may maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule.

(6) Nothing in this section impairs the right of a provider to charge, collect from, and attempt to collect from or maintain a civil action against a member for any of the following:

(a) Deductible, copayment or coinsurance amounts;

(b) Health services not covered by the CCO; or

(c) Health services rendered after the termination of the contract between the CCO and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

(7) Nothing in this rule prohibits a member from seeking noncovered health services from a provider and accepting financial responsibility for these services, subject to requirements of the Authority about how those arrangements may be made under appropriate waiver.

(8) No CCO shall limit the right of a provider of health services to contract with the patient for payment of services not within the scope of the coverage offered by the CCO, subject to requirements of the Authority about how those arrangements may be made under appropriate waiver.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650

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-authorizations 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 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 pre-authorized 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.

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

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2) and 65, HB 3650