Division of Medical Assistance Programs
Coordinated Care Support Unit

Oregon Health Plan (MCO and CCO) Administrative Rulebook

Chapter 410, Division 141

Effective November 6, 2015

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410-141-0000 – Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division), or the Addictions and Mental Health Division (AMH) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions; 410-200-0015, General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411 or 413 administrative rules; or contact the Division.

(1) “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) “Action” means a termination, suspension, or reduction of eligibility or covered services.

(3) “Acupuncturist” means a person licensed to practice acupuncture by the relevant state licensing board.

(4) “Acupuncture Services” means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(5) “Acute” means a condition, diagnosis, or illness with a sudden onset and that is of short duration.

(6) “Acquisition Cost” means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.

(7) “Addiction and Mental Health Division (AMH)” means a division within the Authority that administers mental health and addiction programs and services.

(8) “Adequate Record Keeping” means documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

(9) “Administrative Medical Examinations and Reports” means examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.

(10) “Advance Directive” means an individual’s instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(11) “Adverse Event” means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(12) “Aging and People with Disabilities (APD)” means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named “Seniors and People with Disabilities (SPD).”

(13) “All-Inclusive Rate” or “Bundled Rate” means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division’s Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(14) “Allied Agency” means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(15) “Alternative Care Settings” means sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.

(16) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured persons that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(17) “Ambulatory Payment Classification” means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(18) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.

(19) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims

Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(20) “American Indian/Alaska Native (AI/AN) Clinic” means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(21) “Ancillary Services” means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.

(22) “Anesthesia Services” means administration of anesthetic agents to cause loss of sensation to the body or body part.

(23) “Appeal” means a request for review of an action.

(24) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(25) “Atypical Provider” means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(26) “Audiologist” means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(27) “Audiology” means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(28) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone or web-based response.

(29) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.

(30) “Behavioral Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.

(31) “Behavioral Health Case Management” means services provide 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.

(32) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

(33) “Benefit Package” means the package of covered health care services for which the client is eligible.

(34) “Billing Agent or Billing Service” means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(35) “Billing Provider (BP)” means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.

(36) “Buying Up” means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up.)

(37) “By Report (BR)": means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(38) “Case Management Services” means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

(39) “Certified Traditional Health Worker” means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.

(40) “Child Welfare (CW)” means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.

(41) “Children's Health Insurance Program (CHIP)” means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.

(42) “Chiropractor” means a person licensed to practice chiropractic by the relevant state licensing board.

(43) “Chiropractic Services” means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

(44) “Citizen/Alien-Waived Emergency Medical (CAWEM)” means aliens granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (3)(f).

(45) “Claimant” means a person who has requested a hearing.

(46) “Client” means an individual found eligible to receive OHP health services. “Client” is inclusive of members enrolled in PHPs and CCOs.

(47) “Clinical Nurse Specialist” means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

(48) “Clinical Social Worker” means a person licensed to practice clinical social work pursuant to state law.

(49) “Clinical Record” means the medical, dental, or mental health records of a client or member.

(50) “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.

(51) “Comfort Care” means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

(52) “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.

(53) “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).

(54) “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, that, 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.

(55) “Contested Case Hearing” means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an action:

(a) A client or member or their representative;

(b) A PHP or CCO member’s provider; or

(c) A PHP or CCO.

(56) “Contiguous Area” means the area up to 75 miles outside the border of the State of Oregon.

(57) “Contiguous Area Provider” means a provider practicing in a contiguous area.

(58) “Continuing Treatment Benefit” means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client’s benefit package changed to one that does not cover the treatment.

(59) “Coordinated Care Organization (CCO)” as defined in OAR 410-141-0000.

(60) “Co-Payments” means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment.)

(61) “Cost Effective” means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

(62) “Covered Services” means 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.

(63) “Current Dental Terminology (CDT)” means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(64) “Current Procedural Terminology (CPT)” means the physicians' CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(65) “Date of Receipt of a Claim” means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(66) “Date of Service” means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(67) “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 that is honored when the individual is unable to make such decisions.

(68) “Dental Emergency Services” means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(69) “Dental Services” means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(70) “Dentist” means a person licensed to practice dentistry pursuant to state law of the state in which he or she practices dentistry or a person licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.

(71) “Denturist” means a person licensed to practice denture technology pursuant to state law.

(72) “Denturist Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

(73) “Dental Hygienist” means a person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.

(74) “Dental Hygienist with an Expanded Practice Permit” means a person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.

(75) “Dentally Appropriate” means services that are required for prevention, diagnosis, or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the client or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a client.

(76) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

(77) “Department Representative” means a person who represents the Department and presents the position of the Department in a hearing.

(78) “Diagnosis Code” means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules.

Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(79) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(80) “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.

(81) “Division of Medical Assistance Programs (Division)” means a division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.

(82) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.

(83) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(84) “Electronic Data Interchange (EDI)” means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(85) “EDI Submitter” means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(86) “Electronic Verification System (EVS)” means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

(87) “Emergency Department” means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(88) “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

(89) “Emergency Medical Transportation” means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(90) “Emergency Services” means health 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.

(91) “Evidence-Based Medicine” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

(92) “False Claim” means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such

inaccurate, misleading, or omitted information would result, or has resulted, in an overpayment.

(93) “Family Planning Services” means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.

(94) “Federally Qualified Health Center (FQHC)” means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(95) “Fee-for-Service Provider” means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

(96) “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(97) “Fully Dual Eligible” means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(98) “General Assistance (GA)” means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.

(99) “Health Care Interpreter” Certified or Qualified as defined in ORS 413.550.

(100) “Health Care Professionals” means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

(101) “Healthcare Common Procedure Coding System (HCPCS)” means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(102) “Health Evidence Review Commission” means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most

to the least important representing the comparative benefits of each service to the population served.

(103) “Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)” means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.

(104) “Health Maintenance Organization (HMO)” means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(105) “Health Plan New/non-categorical client (HPN)” means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.

(106) “Hearing Aid Dealer” means a person licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(107) “Home Enteral Nutrition” means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(108) “Home Health Agency” means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(109) “Home Health Services” means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(110) “Home Intravenous Services” means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(111) “Home Parenteral Nutrition” means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other

medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(112) “Hospice” means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(113) “Hospital” means a facility licensed by the Office of Public Health Systems as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as long-term care hospitals, long-term acute care hospitals, or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(114) “Hospital-Based Professional Services” means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (division 42) report for the Division.

(115) “Hospital Dentistry” means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(116) “Hospital Laboratory” means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(117) “Indian Health Care Provider” means an Indian health program or an urban Indian organization.

(118) “Indian Health Program” means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

(119) “Indian Health Service (IHS)” means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.

(120) “Indigent” means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private,

who meet standards for indigence adopted by the federal government as defined in 813.602(5).

(121) “Individual Adjustment Request Form (DMAP 1036)” means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(122) “Inpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(123) “Institutional Level of Income Standards (ILIS)” means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.

(124) “Institutionalized” means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.

(125) “International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)” means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(126) “Laboratory” means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).

(127) “Laboratory Services” means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his or her scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(128) “Licensed Direct Entry Midwife” means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.

(129) “Liability Insurance” means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner’s liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(130) “Managed Care Organization (MCO)” means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(131) “Maternity Case Management” means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division’s Medical-Surgical Services program administrative rules.

(132) “Medicaid” means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.

(133) “Medical Assistance Eligibility Confirmation” means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

(134) “Medical Assistance Program” means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.

(135) “Medical Care Identification” means the card commonly called the “medical card” or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).

(136) “Medical Services” means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(137) “Medical Transportation” means transportation to or from covered medical services.

(138) “Medically Appropriate” means services and medical supplies that are required for prevention, diagnosis, or treatment of a health condition that encompasses physical or mental conditions or injuries and that are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine, and professional standards of care as effective;

(c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Division client or CCO member in the Division or CCO's judgment.

(139) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(140) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(141) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(142) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(143) “National Correct Coding Initiative (NCCI)” means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(144) “National Drug Code or (NDC)” means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

(145) “National Provider Identification (NPI)” means federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare covered entities are required to apply for an NPI.

(146) “Naturopathic physician” means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(147) “Naturopathic Services” means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine..

(148) “Non-covered Services” means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations; and

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) Any other applicable Division administrative rules.

(149) “Non-Emergent Medical Transportation Services (NEMT)”means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000(76) and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(150) “Non-Paid Provider” means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

(151) “Nurse Anesthetist, C.R.N.A.” means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

(152) “Nurse Practitioner” means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.

(153) “Nurse Practitioner Services” means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

(154) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

(155) “Nursing Services” means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.

(156) “Nutritional Counseling” means counseling that takes place as part of the treatment of a person with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(157) “Occupational Therapist” means a person licensed by the State Board of Examiners for Occupational Therapy.

(158) “Occupational Therapy” means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(159) “Ombudsman Services” means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.

(160) “Oregon Health ID” means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.

(161) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan

(162) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.

(163) “Optometrist” means a person licensed to practice optometry pursuant to state law.

(164) “Oregon Health Authority (Authority)” means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(165) “Oregon Youth Authority (OYA)” means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.

(166) “Out-of-State Providers” means any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(167) “Outpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division’s Hospital Services administrative rules found in chapter 410, division 125.

(168) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.

(169) “Overpayment” means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(170) “Overuse” means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

(171) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(172) “Panel” means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(173) “Payment Authorization” means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(174) “Peer Review Organization (PRO)” means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.

(175) “Peer Wellness Specialist” means an individual who is responsible for assessing mental health service and support needs of the individual’s peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

(176) “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.

(177) “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 outcome.

(178) “Pharmaceutical Services” means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his or her scope of practice.

(179) “Pharmacist” means a person licensed to practice pharmacy pursuant to state law.

(180) “Physical Capacity Evaluation” means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(181) “Physical Therapist” means a person licensed by the relevant state licensing authority to practice physical therapy.

(182) “Physical Therapy” means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.

(183) “Physician” means a person licensed to practice medicine pursuant to state law of the state in which he or she practices medicine or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

(184) “Physician Assistant” means a person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(185) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

(186) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.

(187) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to state law.

(188) “Post-Payment Review” means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.

(189) “Practitioner” means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.

(190) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(191) “Primary Care Dentist (PCD)” means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

(192) “Primary Care Provider (PCP)” means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.

(193) “Prior Authorization (PA)” means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.

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

(195) “Private Duty Nursing Services” means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.

(196) “Provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.

(197) “Provider Organization” means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)

(198) “Public Health Clinic” means a clinic operated by a county government.

(199) “Public Rates” means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

(200) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.

(201) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.

(202) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.

(203) “Quality Improvement Organization (QIO)” means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

(204) “Radiological Services” means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.

(205) “Recipient” means a person who is currently eligible for medical assistance (also known as a client).

(206) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(207) “Recoupment” means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

(208) “Referral” means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

(209) “Remittance Advice (RA)” means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(210) “Rendering provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

(211) “Request for Hearing” means a clear expression in writing by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(212) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(213) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

(214) “Ride” means non-emergent medical transportation services for a client either to or from a location where covered services are provided. “Ride” does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.

(215) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

(216) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.

(217) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(218) “Self-Sufficiency” means the division in the Department of Human Services (Department) that administers programs for adults and families.

(219) “Service Agreement” means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(220) “Sliding Fee Schedule” means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(221) “Social Worker” means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(222) “Speech-Language Pathologist” means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(223) “Speech-Language Pathology Services” means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or

instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(224) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(225) “Subparts (of a Provider Organization)” means for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.

(226) “Subrogation” means right of the state to stand in place of the client in the collection of third party resources (TPR).

(227) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(228) “Supplemental Security Income (SSI)” means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.

(229) “Surgical Assistant” means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(230) “Suspension” means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(231) “Targeted Case Management (TCM)” means activities that will assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.

(232) “Termination” means a sanction prohibiting a provider's participation in the Division’s programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

(233) “Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer” means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.

(234) “Transportation” means medical transportation.

(235) “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.

(236) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.

(237) “Type B AAA” means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.

(238) “Type B AAA Unit” means a Type B AAA funded by Oregon Project Independence (OPI), Title III—Older Americans Act, and Title XIX of the Social Security Act.

(239) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.

(240) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

(241) “Urgent Care Services” means health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of unforeseen illness or injury.

(242) “Usual Charge (UC)” means the lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of

the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(243) “Utilization Review (UR)” means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(244) “Valid Claim” means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(245) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member 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, except for cases of PHP or CCO enrollment where four months may apply; and

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

(246) “Vision Services” means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(247) “Volunteer” (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-141-0010 – Prepaid Health Plan Contract Procurement Screening and Selection Procedures

(1) Basis and scope:

(a) The Oregon Health Authority (Authority) will use screening and selection procedures to procure managed care services pursuant to ORS 414.725. The Authority may award Qualified Managed Care Organizations (MCO) a contract as a prepaid health plan (PHP) for purposes of administering the Oregon Health Plan (OHP);

(b) The OHP is funded with Federal Medicaid funds. The Authority will interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with PHPs. The Authority will seek prior federal approval of PHP contracts;

(c) For purposes of source selection and screening in the procurement of managed care services, the Authority may use:

(A) The Request for Application (RFA) process described in sections (3) through (6) of this rule; or

(B) Any method described in the Department of Justice's (DOJ) Model Rules (chapter 137, division 047) for source selection and procurement process, except for bidding.

(2) In addition to the terms defined in OAR 410-141-0000, the following definitions for screening and selection procedures apply:

(a) Addendum or Addenda -- an addition or deletion to, a material change in, or general interest explanation of an RFA;

(b) Application -- Documents submitted by an MCO that seeks qualification to be awarded a contract. The applicant is the MCO submitting the Application;

(c) Award -- As the context requires, the act or occurrence of the Authority's identification of a qualified MCO with which the Authority will enter into a contract;

(d) Closing -- The date and time announced in an RFA as the deadline for submitting Applications;

(e) MCO -- A corporation, governmental agency, public corporation or other legal entity that operates as a managed health, dental, chemical dependency, physician care, or mental health organization;

(f) Managed care services -- Capitated services provided by a PHP pursuant to ORS 414.725;

(g) Offer -- A response to an RFA, including all required responses and assurances, and the Certification of Application;

(h) Request for Applications (RFA) -- All documents used by the Authority for soliciting Applications for qualification in a specific RFA issued by the Authority, for one or more categories of contracts, one or more Service Areas or such other objective as the Authority may determine is appropriate for solicitation of managed care services.

(3) RFA process:

(a) The Authority will provide public notice of every RFA on its Web site. The RFA will indicate how prospective applicants will be made aware of Addenda by posting notice of the RFA on the electronic system for notifying the public of Authority procurement opportunities, or at the option of the requestor, mailing notice of the availability of the RFA to persons that have expressed interest in Authority procurement of managed care services;

(b) The RFA process begins with a public notice of the RFA, which will be communicated with the electronic notification system used by the Authority to notify the public of procurement opportunities. A public notice of a RFA shall identify the qualification requirements for the category of contract (e.g., Fully Capitated Health Plan FCHP), Dental Care Organization (DCO), etc.), the designated Service Area(s) where managed care services are requested or other objective that the Authority determines appropriate for solicitation of managed care services, and a sample contract;

(c) The Authority will provide notice of any RFA Addenda in a manner intended to foster competition and to make prospective applicants aware of the Addenda. The RFA will specify how the Authority will provide notice of Addenda;

(d) If the RFA so specifies, potential applicants must submit a letter of intent to the Authority within the time period specified in the RFA. The letter of intent does not commit any potential applicant to apply, however, if required, the Authority will not consider Applications from applicants who do not submit a timely letter of intent;

(e) Submitting the Application – The Authority will only consider Applications that are submitted in the manner described in the RFA. Applicants must:

(A) Identify electronic Application submissions as defined in the RFA. The Authority is not responsible for any failure attributable to the transmission or receipt of electronic or facsimile Applications, including but not limited to receipt

of garbled or incomplete documents, delay in transmission or receipt of documents, or security and confidentiality of data;

(B) Submit Applications, when sent by mail, in a sealed envelope that is marked appropriately;

(C) Ensure the Authority receives their Applications at the required delivery point prior to the Closing date, listed in the RFA. The Authority will not accept late Applications.

(f) The Application must be completed as described in the RFA. To avoid duplication and burden, the Authority may permit a current contractor to submit an abbreviated Application that focuses only on additional or different requirements specific to the new contract or the new Service Area or capacity or other Authority objective that is the subject of the RFA;

(g) The Authority will enter into or renew a contract only if it determines that the action would be within the scope of the RFA and consistent with the effective administration of the OHP, including but not limited to:

(A) The capacity of any existing PHP(s) in the Service Area compared to the capacity of an additional PHP for the number of potential enrollees in the Service Area;

(B) The potential opportunity for clients to have a choice of more than one PHP.

(h) Disclosure of Application Contents and Release of Information:

(A) Application information, including the letter of intent, shall not be disclosed to any applicant (or other person) until the completion of the RFA process. The RFA process shall be considered complete when a contract has been awarded. No information will be given to any applicant (or other person) relative to their standing with other applicants during the RFA process;

(B) Application information shall be subject to disclosure upon the award date, with the exception of information that has been clearly identified and labeled "Confidential" under ORS 192.501-192.502, insofar as the Authority determines it meets the requirements for an exemption from disclosure;

(C) Any requestor shall be able to obtain copies of non-exempt information after the RFA process has been completed. The requestor shall be responsible for the time and material expense associated with the request. This fee includes the copying of the document(s) and the staff time (and agency attorney time, if requested by the Authority) associated with performing the task, in accordance with ORS 192.440(3). The Authority may require prepayment of estimated charges before acting on a request:

(i) Protests must be submitted, in writing, to the Authority prior to the protest date specified in the RFA. The protest shall state the reasons for the protest or request and any proposed changes to the RFA provisions, specifications or contract terms and conditions that the prospective applicant believes will remedy the conditions upon which the protest is based. Protests and judicial review of the RFA shall be handled using the process set forth in OAR 137-047-0730;

(j) The Authority is not obligated to enter into a contract with any applicant, and further, has no financial obligation to any applicant.

(4) Application for qualification:

(a) An MCO seeking qualification as a PHP must meet the requirements and provide the assurances specified in the RFA. The Authority determines whether the MCO qualifies based on the Application and any additional information and investigation that the Authority may require;

(b) The Authority determines an MCO is qualified when the MCO meets the requirements of the RFA, including written assurances, satisfactory to the Authority, that the MCO:

(A) Provides or will provide the services described in the contract;

(B) Provides or will provide the health services described in the contract in the manner described in the contract;

(C) Is organized and operated, and will continue to be organized and operated, in the manner required by the contract and described in the Application;

(D) Under arrangements that safeguard the confidentiality of patient information and records, will provide to the Authority, CMS, the Office of Inspector General, the Oregon Secretary of State, and the Oregon Medicaid Fraud Unit of the DOJ, or any of their duly authorized representatives, for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the MCO relating to its operation as a PHP and to any facilities that it operates; and

(E) Will continue to comply with any other assurances it has given the Authority.

(c) The Authority may determine that an MCO is potentially qualified if within a specified period of time the MCO is reasonably susceptible of being made qualified. The Authority is not obligated to determine whether an applicant is potentially qualified if, in its discretion, the Authority determines that sufficient qualified applicants are available to obtain the Authority objectives under the RFA. The Authority determines that an MCO is potentially qualified if:

(A) The Authority finds that the MCO is reasonably susceptible to meeting the operational and solvency requirements of the Application within a specified period of time; and

(B) The MCO enters into discussions with the Authority about areas of qualification that must be met before the MCO is operationally and financially qualified. The Authority will determine the date and required documentation and written assurances required from the MCO;

(C) If the Authority determines that a potentially qualified applicant cannot become a qualified MCO within the time announced in the RFA for contract award, the Authority may:

(i) Offer the contract at a future date when the applicant demonstrates, to the Authority's satisfaction, that the applicant is a qualified MCO within the scope of the advertised RFA; or

(ii) Inform the applicant that it is not qualified for contract award.

(5) Evaluation and determination procedures:

(a) The Authority evaluates an Application for qualification on the basis of information contained in the RFA, the Application and any additional information that the Authority obtains. Evaluation of the Application will be based on the criteria in the RFA;

(b) The Authority will notify each MCO that applies for qualification of its qualification status;

(c) Review of Authority' qualification decisions shall be as set forth in ORS 279B.425;

(d) The Authority may enter into negotiation with qualified or potentially qualified applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity and the number of potential enrollees within the Service Area. The Authority may determine that it will limit contract award(s) to fewer than the number of qualified or potentially qualified applicants, to achieve the objectives in the RFA.

(6) Contract award conditions:

(a) The applicant's submission of the Application with the executed Certification of Application is the MCO's Offer to enter into a contract. The Offer is a "Firm Offer," i.e., the Offer shall be held open by the applicant for the Authority' acceptance 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;

(b) No Contingent Offers. Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an MCO shall not make its Offer contingent upon the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(c) By timely signing and submitting the Application and Certification of Application, the applicant acknowledges that it has read and understands the terms and conditions contained in the RFA and that it accepts and agrees to be bound by the terms and conditions of the RFA;

(d) The Authority may award multiple contracts in accordance with the criteria set forth in the RFA. The Authority may make a single award or limited number of awards rather than multiple awards to all qualified or potentially qualified applicants, in order to meet Authority' needs including but not limited to adequate capacity for the potential enrollees in the Service Area;

(e) An applicant who claims to have been adversely affected or aggrieved by the Authority contract award or intent to award a contract must file a written protest with the Authority issuing office within seven (7) calendar days after receiving the Notice of Award. Protests and judicial review of contract award shall be handled using the procedures set forth in OAR 137047-9740.

(7) Applicability of DOJ Model Rules: Except where inconsistent with the preceding sections of this rule, Authority will use the following DOJ Model Rules to govern solicitations for Managed Care Services:

(a) OAR 137-046 -- General Provisions Related to Public Contracting: 137046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 -- Public Procurements for Goods or Services: 137-0470100, 137-047-0260 through 137-047-0330, 137-047-0400 through 137047-0800.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0020 – Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence

(1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.725 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) 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 Division will construe them as much as possible to be complementary. In the event that the Division's policies, procedures, rules and interpretations may not be complementary, the Division will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to the Division clients, including but not limited to authorization and delivery of service, or denials of authorization or services, the Division, clients, enrolled Providers and the Prepaid Health Plans (PHP) will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Division by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan (OHP);

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for PHP, requirements applicable to the provision of covered medical assistance to the Division clients are provided in OAR 410-1410000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, the Division's General Rules, 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to

Division clients are provided in the Division's General Rules, OAR 410-1200000 through 410-120-1980, the Prioritized List and program coverage described in 410-141-0480 to 410-141-0520,and the provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Authority necessary to administer the State of Oregon's

medical assistance programs, such as Electronic Data Transaction Rules in OAR 407-120-0100 to 407-120-0200; and

(F) The basic framework for provider enrollment in OAR 407-120-0300 through 407-120-0380 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of the OHP and the Division. For purposes of this rule, “more specific” means the requirements, laws and rules applicable to the provider type and covered services described in subsections (i)-(v) of this section.

(b) For purposes of contract administration solely as between the Division and its PHP, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to the Division clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409.110 and 413.042

Stats. Implemented: 414.065

410-141-0050 – MHO Enrollment for Children Receiving Child Welfare Services

Pursuant to and in the administration of the Authority in OAR 410-141-0060, Children, Adults and Families (CAF) or the Oregon Youth Authority (OYA) selects Prepaid Health Plans (PHPs) for a child receiving CAF Child Welfare services or OYA services with the exception of children in subsidized adoption and guardianship. This rule implements and further describes how the Oregon Health Authority (Authority) shall administer its authority under OAR 410-141-0060 and 410-141-3060 for purposes of making enrollment decisions and OAR 410-141-0080 and 410-141-3080 for purposes of making disenrollment decisions for children receiving CAF Child Welfare services or OYA services;

(1) The Authority has determined that, to the maximum extent possible, all children receiving CAF services should be enrolled in Mental Health Organizations (MHOs) or Coordinated Care Organizations (CCO) at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment from a MHO or CCO is authorized by the Authority in accordance with this section and OAR 410-141-0080 and 410-141-3080:

(a) Notwithstanding OAR 410-141-0060(4)(a) or 410-141-3060 or 410-141-0080(2)(b)(E) or 410-141-3080, children receiving CAF services are not exempt from mandatory enrollment in an MHO or CCO on the basis of third party resources (TPR) mental health services coverage;

(b) A decision to use fee-for-service (FFS) open card for a child receiving CAF services should be reviewed by the Authority if the child's circumstances change and at the time of redetermination to consider whether the child should be enrolled in a MHO or CCO.

(2) When a child receiving CAF services is being transferred from one MHO to another or one CCO to another or for children transferring from FFS to a MHO or CCO, the MHO or CCO shall facilitate coordination of care consistent with OAR 410-141-0160 or 410-141-3160:

(a) MHOs and CCOs shall work closely with the Authority to ensure continuous MHO or CCO enrollment for children receiving CAF services;

(b) If the Authority determines that disenrollment should occur, the MHO or CCO shall continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible MHO or CCO.

(3) It is not unusual for a child receiving CAF services to experience a change of placement that may be permanent or temporary in nature. Consistent with OAR 410-141-0080 or 410-141-3080, the Authority will verify the address change information to

determine whether a child receiving CAF services no longer resides in the MHO's or CCO's service area:

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

(b) Unless a corresponding change in MHO capitation rates is implemented, a child receiving CAF services placed in behavioral rehabilitation services (BRS) settings shall be enrolled in the MHO or CCO that serves the region in which the BRS setting is located, unless an out of area exception is requested by the MHO or CCO and agreed to by the Authority for purposes related to continuity of care.

(4) If the child receiving CAF services is enrolled in a MHO or CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the MHO or CCO shall be responsible for covered services during that placement even if the location of the facility is outside of the MHO's or CCO service area:

(a) The child receiving CAF services is presumed to continue to be enrolled in the MHO or CCO with which the child was most recently enrolled. An admission to a PRTS facility shall be deemed a temporary placement for purposes of MHO or CCO enrollment. Any address change or Authority system identifier (e.g., C5 status) change associated with the placement in the PRTS facility does not constitute a change of residence for purposes of MHO or CCO enrollment and shall not constitute a basis for disenrollment from the MHO or CCO, notwithstanding OAR 410-141-0080 and 410-141-3080. If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate MHO or CCO and assign an enrollment date that provides for continuous MHO or CCO coverage with the appropriate MHO or CCO. If the child had been enrolled in a different MHO or CCO in error, the Authority shall disenroll the child from that MHO or CCO and recoup the capitation payments;

(b) Immediately upon discharge from long-term psychiatric care and prior to admission to a PRTS, a child receiving CAF services should be enrolled in an MHO or CCO. At least two weeks prior to discharge of a child receiving CAF services from a long-term psychiatric care (SAIP, SCIP, or STS) facility to a PRTS facility, the long-term care facility shall consult with the Authority about which MHO or CCO will be assigned in order to provide for enrollment in the MHO or CCO and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge from long-term psychiatric care.

(5) Notwithstanding OAR 410-141-0060(6) and (7), 410-141-3060, 410-141-0080, and 410-141-3080, if a child receiving CAF services is enrolled in a MHO or CCO after the first day of an admission to PRTS, the date of enrollment shall be effective the next

available enrollment date following discharge from PRTS to the MHO or CCO assigned by the Authority:

(a) For purposes of these rules and to assure continuity of care for the child upon discharge, the next available enrollment date shall mean immediately upon discharge;

(b) At least two weeks prior to discharge, the PRTS facility shall consult with the Authority about which MHO or CCO will be assigned and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-141-0060 – Oregon Health Plan Managed Care Enrollment Requirements (T)

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

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

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

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

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

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

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

(2) The following populations may not be enrolled into an MCO or any type of health care coverage including:

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

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

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

(3) The following populations may not be enrolled into an MCO under the following circumstances:

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

basis only until the hospital discharges the client. The individual will receive dental services through the DCO.

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

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

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

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

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

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

(A) A client who is also a Medicare beneficiary and is in a hospice program may not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan unless exempt for some other reason listed in this rule;

(B) The client is enrolled in Medicare and the only FCHP or PCO in the service area is a Medicare Advantage plan. The client may choose not to enroll in an FCHP or PCO;

(C) Enrollment in a FCHP or PCO of a client who is receiving Medicare and who resides in a service area served by PHPs shall be as follows:

(i) If the client who is Medicare Advantage eligible selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the client shall complete the 7208M or other CMS approved Medicare plan election form;

(ii) If the Medicare Advantage Plan Election form (OHP 7208M) described in this rule is signed by someone other than the client, the client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M;

(iii) If the client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative may not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components:

(I) If the FCHP or PCO has not received the form within ten calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the member with a copy sent to the APD branch manager. The letter shall explain the need for the completion of the form; inform the member that if the form is not received within 30 days, the FCHP or PCO may request disenrollment; and instruct the member to contact their caseworker for other coverage alternatives.

(II) The FCHP or PCO shall choose whether to disenroll or maintain enrollment for all the clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO shall notify the PHP coordinator of the PHP's annual decision to disenroll or maintain enrollment for the clients in writing. This notification shall be submitted by January 31 of each year or another date specified by the Authority. If the FCHP or PCO has decided to:

(III) Disenroll the clients and has not received a client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the member effective the end of the month following the notification;

(D) Maintain enrollment. The FCHP or PCO may not request disenrollment at the end of 30 days.

(E) If the client is enrolled as a private member of a Medicare Advantage plan, the client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:

(F) If the client chooses to remain as a private member in the Medicare Advantage plan, the client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(G) If the client chooses to discontinue the Medicare Advantage enrollment and then, within 60 calendar days of disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other clients;

(H) A Fully Dual Eligible (FDE) client who has been exempted from enrollment in an MHO may not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

(6) The Authority may temporarily exempt clients from mandatory enrollment for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in MCOs on a case-by-case basis; children not enrolled in a MCO shall continue to receive services on a FFS basis;

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

(A) Be pregnant;

(B) State that her intention is to have a home birth;

(C) Have an established relationship for the purpose of home birth with a licensed qualified practitioner who is not a participating provider with the client’s MCO;

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

(E) Meet all administrative rules including, but not limited to, OAR 410-141-0240 and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1), Table 1, either upon initial evaluation or once the

exemption is granted, the exemption shall be withdrawn, and the client will be subject to MCO enrollment requirements as stated in OAR 410-141-3060;

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

(I) Fetal presentation other than vertex when known;

(II) Abnormal bleeding;

(III) Low–lying placenta within 2 cm. or less of cervical os;

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

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

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

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

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

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

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

(B) The Authority finds no reasonable alternatives.

(7) Unless exempted above, enrollment is mandatory in all areas served by an MCO.

(8) When a service area changes from mandatory to voluntary, the member will remain with their PHP for the remainder of their eligibility period unless the member meets the criteria stated in this rule or as provided by OAR 410-141-0080.

(9) If the client resides in a mandatory service area and fails to select a DCO, MHO, PCO, or FCHP at the time of application for the OHP, the Authority shall enroll the client with a DCO, MHO, PCO, or FCHP as follows:

(a) The client shall be assigned to and enrolled with a DCO, MHO, PCO, or FCHP that meets the following requirements where MCO enrollment is not available or services are not available through the MCO:

(A) Is open for enrollment;

(B) Serves the county in which the client resides;

(C) Has practitioners located within the community-standard distance for average travel time for the client.

(b) Assignment shall be made first to an MCO;

(c) The Authority shall send a notice to the client informing the client of the assignments and the right to change assignments within 30 calendar days of enrollment. A change in assignment shall be honored if there is another DCO, MHO, PCO, or FCHP open for enrollment in the county in which the client resides;

(10) Clients shall be enrolled with PHPs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHP), and Physician Care Organizations (PCO) shall be called mandatory service areas. In mandatory service areas, a client shall select:

(A) A CCO; or

(B) An FCHP or PCO:

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority.

(b) Service areas without sufficient physical health service capacity shall be called voluntary service areas. In voluntary service areas, a client has the option to:

(A) Select a CCO; or

(B) Select an FCHP or PCO;

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority; or

(C) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.

(c) Service areas with sufficient mental health and dental care service capacity through MHOs and DCOs shall be called mandatory MHO and DCO service areas. A client shall select an MHO and DCO in a mandatory MHO and DCO service area if mental health and dental services are not available through a CCO or the client is otherwise exempt from CCO enrollment;

(d) Service areas without sufficient dental care service capacity through MHOs and DCOs shall be called voluntary MHO and DCO service areas. In voluntary MHO and DCO service areas, a client may choose to:

(A) Select a CCO open to enrollment that offers dental services; or

(B) Select any MHO and DCO open for enrollment if CCO enrollment is not available; or

(C) Remain in the Medicaid FFS mental health and dental care delivery system;

(11) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the client and notifies the client of enrollment and the name of the PHP: If enrollment is initiated by an Authority worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by an Authority worker after Wednesday, the date of enrollment shall be one week from the following Monday. Monthly enrollment in a mandatory service area, where there is only one plan or DCO, shall be initiated by an auto-enrollment program of the Authority, effective the first of the month following the month-end cutoff. Monthly enrollment in service areas, where there is a choice of PHPs, shall be auto-enrolled by computer algorithm.

(12) The provision of capitated services to a member enrolled with a PHP shall begin as of the effective date of enrollment with the MCO except for:

(a) A newborn whose mother was enrolled at the time of birth. The date of enrollment shall be the newborn's date of birth;

(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

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

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 & 414.685

410-141-0065 – Fully Capitated Health Plan or Physician Care Organization (FCHP or PCO) Enrollment Requirements for Individuals Receiving Residential Substance Use Disorder (SUD) Treatment Services

This rule implements and further describes how the Oregon Health Authority (Authority) will administer its authority under 410-141-0060 for purposes of making enrollment decisions and 410-141-0080 for purposes of making disenrollment decisions for the adult and adolescent individuals receiving residential SUD treatment services;

(1) The Authority has determined that, to the maximum extent possible, all individuals should be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment is authorized by the Authority in accordance with this section, OAR 410-141-0050 and OAR 410-141-0080

(2) If the Authority determines that disenrollment should occur, the FCHP or PCO will continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible FCHP or PCO when applicable.

(3) It is not unusual for individuals to receive residential SUD treatment services outside of their residential or home county and outside of the FCHP or PCO's delivery service area. Receiving residential SUD treatment is considered a temporary absence from the individual's residential or home county and does not represent a change of residence or a change in enrollment when the individual is reasonably likely to return to the FCHP or PCO's delivery service area at the end of the residential treatment stay.

(4) If the individual is enrolled in a FCHP or PCO on the same day the individual is admitted to the residential treatment services, the managed care organization shall be responsible for the covered services during that placement even if the location of the facility is outside of the FCHP or PCO's service area;

(5) The individual is presumed to continue to be enrolled in the FCHP or PCO with which the individual was most recently enrolled. An admission to a residential SUD facility is deemed a temporary placement and does not constitute a change of residence for the purposes of FCHP or PCO enrollment and does not constitute a basis for disenrollment from the FCHP or PCO, notwithstanding OAR 410-1 41-0080(2)(b)(F). If the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority will re-enroll the individual with the appropriate FCHP or PCO and assign an enrollment date that provides for continuous FCHP or PCO coverage with the appropriate FCHP or PCO. If the individual was enrolled in a different FCHP or PCO in error, the Authority will disenroll the individual and recoup the capitation payments.

(6) If the individual is en rolled in a FCHP or PCO after the first day of an admission to a residential SUD treatment service facility, the individual will be retro effectively

disenrolled from the FCHPO or PCO, and capitation will be recouped. The date of enrollment shall be effective the next available enrollment date following discharge from the residential FCHP or PCO treatment service facility.

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

Stats. Implemented: ORS 414.610-685

410-141-0070 – Managed Care Fully Capitated Health Plan and Physician Care Organization Pharmaceutical Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. Fully Capitated Health Plan (FCHP)'s and Physician Care Organization (PCO)'s 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 Division of Medical Assistance Programs (Division) 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) FCHPs and PCOs 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 (FDA) Federal Drug Administration- 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) FCHPs and PCOs 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 is 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 of drugs and the medical need for the drug is immediate, FCHPs and PCOs 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) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) 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 Division member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall 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/12 LTEIRSDrugs.asp.

(8) An FCHP or PCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Division no later than March 1 of any given contract year that contains all of the following information:

(a) The name of the drug;

(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 Division should consider this drug for carve out.

(9) Upon receipt of a request from an FCHP or PCO requesting a drug not be paid within the capitation rate of the FCHP or PCO, the Division shall exclude the drug from capitation rate for the following January contract cycle if the Division 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 Division will pay for a drug that is not included in the capitation rate pursuant to the Pharmaceutical Services Program rules (chapter 410, division 121). An FCHP or PCO may not reimburse providers for carved out drugs.

(11) FCHPs and PCOs shall submit quarterly utilization data, within 60 days of the date of service, as part of the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

0410-141-0080 – Managed Care Disenrollment from Prepaid Health Plans

For purposes of this rule Managed Care Prepaid Health Plan means Fully Capitated Health Plan, Dental Care Organization, Physician Care Organization and Mental Health Organization.

(1) All Oregon Health Plan (OHP) Division member-initiated requests for disenrollment from a Prepaid Health Plan (PHP) must be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For Division members who are not able to request disenrollment on their own, the request may be initiated by the Division member's Representative.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority and PHP shall honor a member or Representative request for disenrollment for the following:

(a) Without cause:

(i) Newly eligible clients may change their PHP assignment within 90 days following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(ii) At least once every 12 months;

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

(iv) Effective retroactively on or after September 1, 2011 and in accordance with SB 201 Division members may disenroll from a PHP during their redetermination (enrollment period), or one additional time during their enrollment period based on the member's choice and with Authority approval. The disenrollment shall be considered "recipient choice".

(b) With cause:

(A) At any time;

(B) Division members who disenroll from a Medicare Advantage plan shall also be disenrolled from the corresponding Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). The effective date of disenrollment shall be the first of the month that the Division member's Medicare Advantage plan disenrollment is effective;

(C) Division members who are receiving Medicare and who are enrolled in a FCHP or PCO that has a corresponding Medicare Advantage component may disenroll from the FCHP or PCO at any time if they also request disenrollment

from the Medicare Advantage plan. The effective date of disenrollment from the FCHP or PCO shall be the first of the month following the date of request for disenrollment;

(D) PHP does not cover the service the Division member seeks because of moral or religious objections;

(E) The Division 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 Division member's Primary Care Provider or another Provider determines that receiving the services separately would subject the Division member to unnecessary risk; or

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

(i) The Division member moves out of the PHP's Service Area;

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

(iii) Continuity of care that is not in conflict with any section of 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any Oregon Health Plan client has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an Oregon Health Plan client or a provider of a treatment, service or supply, including but not limited to a decision of a provider to participate or decline to participate in a PHP;

(iv) If 500 or more Division members choose to change plans in order to continue receiving care from a provider that is terminating their contractual relationship with a PHP, the Division shall send all of the Division Members a written notice 90 days in advance of the termination date;

(I) The member and all family (case) members shall be transferred to the provider's new PHP;

(II) The transfer shall take effect when the provider's contract with their current PHP contractual relationship ends, or on a date approved by the Division.

(c) If the following conditions are met:

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

(B) The new FCHP or PCO the Division member is enrolled with does not contract with the Division member's current OB Provider and the Division member wishes to continue obtaining maternity services from that Non-Participating OB Provider; and

(C) The request to change FCHPs, PCOs or return to FFS is made prior to the date of delivery.

(d) Division member disenrollment requests are subject to the following requirements:

(A) The Division member shall join another PHP, unless the Division member resides in a Service Area where enrollment is voluntary, or the Division member meets the exemptions to enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory Service Area is the PHP from which the Division member wishes to disenroll, the Division member may not disenroll without cause;

(C) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless retroactive disenrollment is approved by the Division;

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

(3) Prepaid Health Plan requests for disenrollment:

(a) Causes for disenrollment:

(A) The Division may disenroll Division members for cause when requested by the PHP, subject to Americans with Disabilities Act requirements. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of missed appointments is to be established by the Provider or PHP. The number must be the same as for commercial members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist

the Division member in receiving services. This rule does not apply to Medicare members who are enrolled in a FCHP's or PCO's Medicare Advantage plan;

(ii) Division member's behavior is disruptive, unruly, or abusive to the point that his/her continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either the Division member or other members, subject to the requirements in (3)(a)(B)(vii);

(iii) Division member commits or threatens an act of physical violence directed at a medical Provider or property, the Provider's staff, or other patients, or the PHP's staff to the point that his/her continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular Division member or other Division members, subject to the requirements in (3)(a)(B)(vii);

(iv) Division member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts (other than those addressed in (3)(a)(A)(ii) or (iii) committed in any Provider or PHP's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) Fraud Unit as appropriate;

(v) OHP clients who have been exempted from mandatory enrollment with a FCHP or PCO, due to the OHP client's eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060(4)(b)(F);

(vi) Division member fails to pay co-payment(s) for Covered Services as described in OAR 410-120-1230.

(B) Division members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

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

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

(iv) Because the Division member requests a hearing;

(v) Because the Division member has been diagnosed with End Stage Renal Disease (ESRD);

(vi) Because the Division member exercises his/her option to make decisions regarding his/her medical care with which the PHP disagrees;

(vii) Because of uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the Division member's special needs (except when continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this Division member or other members).

(C) Requests by the PHP for disenrollment of specific Division members shall be submitted in writing to their PHP Coordinator for approval. The PHP must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below must be followed prior to requesting disenrollment of a Division member:

(i) There shall be notification from the Provider to the PHP at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the PHP. Such notification shall be documented in the Division member's Clinical Record. The PHP shall conduct Provider education regarding the need for early intervention and the services they can offer the Provider;

(ii) The PHP shall contact the Division member either verbally or in writing, depending on the severity of the problem, to inform the Division member of the problem that has been identified, and attempt to develop an agreement with the Division member regarding the issue(s). If contact is verbal, it shall be documented in the Division member's record. The PHP shall inform the Division member that his/her continued behavior may result in disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other interventions with the Division member in a serious effort to resolve the problem;

(iv) The PHP shall contact the Division member's caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution, within the laws governing confidentiality;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of the Provider, caseworker, Division member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain an authorization for release of information from the Division member for the Providers and agencies in order

to involve them in the resolution of the problem. If the release is verbal, it must be documented in the Division member's record;

(vi) Any additional information or assessments requested by the Division PHP Coordinator;

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

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

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

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

(IV) Documentation of any accommodations that have been attempted;

(V) Documentation of the PHP's rationale for concluding that the Division member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular Division member or other members.

(viii) If a Primary Care Provider (PCP) terminates the Provider/patient relationship, the PHP shall attempt to locate another PCP on their panel who will accept the Division member as their patient. If needed, the PHP shall obtain an authorization for release of information from the Division member in order to share the information necessary for a new Provider to evaluate if they can treat the Division member. All terminations of Provider/patient

relationships shall be according to the PHP's policies and must be consistent with PHP or PCP's policies for commercial members.

(D) Requests shall be reviewed according to the following process:

(i) If there is sufficient documentation, the request shall be evaluated by the PHP's Coordinator or a team of PHP Coordinators who may request additional information from Ombudsman Services, AMH or other agencies as needed; If the request involves the Division member's mental health condition or behaviors related to substance abuse, the PHP Coordinator should also confer with the OHP Coordinator in AMH;

(ii) If there is not sufficient documentation, the PHP Coordinator shall notify the PHP within two business days of what additional documentation is required before the request can be considered;

(iii) The PHP Coordinators shall review the request and notify the PHP of the decision within ten working days of receipt of sufficient documentation from the PHP. Written decisions, including reasons for denials, shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the PHP.

(E) If the request is approved the PHP Coordinator must send the Division member a letter within 14 days after the request was approved, with a copy to the PHP, the Division member's caseworker and Division’s Health Management Unit (HMU). The letter must give the disenrollment date, the reason for disenrollment, and the notice of Division member's right to file a Complaint (as specified in 410-141-0260 through 410-141-0266) and to request an Administrative Hearing. If the Division member requests a hearing, the Division member shall continue to be disenrolled until a hearing decision reversing that disenrollment has been sent to the Division member and the PHP:

(i) In cases where the Division member is also enrolled in the FCHP's or PCO's Medicare Advantage plan and the plan has received permission to disenroll the client, the FCHP or PCO shall provide proof of the CMS approval to disenroll the client and the date of disenrollment shall be the date approved by CMS;

(ii) The disenrollment date is 30 days after the date of approval, except as provided in subsections (iii) and (iv) of this section:

(I) The PHP Coordinator shall determine when enrollment in another PHP or with a PCM is appropriate. If appropriate, the PHP Coordinator shall contact the Division member's caseworker to arrange enrollment. The Division may require the Division member and/or the benefit group to

obtain services from FFS Providers or a PCM until such time as they can be enrolled in another PHP;

(II) When the disenrollment date has been determined, HMU shall send a letter to the Division member with a copy to the Division member's caseworker and the PHP. The letter shall inform the Division member of the requirement to be enrolled in another PHP, if applicable.

(iii) If the PHP Coordinator approves a PHP's request for disenrollment because of the Division member's uncooperative or disruptive behavior, including threats or acts of physical violence directed at a medical Provider, the Provider's staff, or other patients, or because the Division member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following additional procedures shall apply:

(I) The Division member shall be disenrolled as of the date of the PHP's request for disenrollment;

(II) All Division members in the Division member's benefit group, as defined in OAR 461-110-0720, may be disenrolled if the PHP requests;

(III) At the time of enrollment into another PHP, the Division shall notify the new PHP that the Division member and/or benefit group were previously disenrolled from another PHP at that PHP's request.

(iv) If a Division member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the PHP Coordinator. A Division member may not be disenrolled from the same PHP for a period of more than 12 months. If the Division member is reenrolled after the 12-month period and is again disenrolled for cause, the disenrollment shall be reviewed by the Division for further action.

(b) Other reasons for the PHP's requests for disenrollment include the following:

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

(B) The Division member has surgery scheduled at the time their enrollment is effective with the PHP, the Provider is not on the PHP's Provider panel, and the Division member wishes to have the services performed by that Provider;

(C) The Medicare member is enrolled in a Medicare Advantage plan and was receiving Hospice Services at the time of enrollment in the PHP;

(D) The Division member had End Stage Renal Disease at the time of enrollment in the PHP;

(E) Excluding the DCO, the PHP determines that the Division member has a third party insurer. If after contacting The Health Insurance Group, and if the disenrollment is not effective the following month, the PHP may contact HMU to request disenrollment;

(F) If a PHP has knowledge of a Division member's change of address, the PHP shall notify the Department. The Department shall verify the address information and disenroll the Division member from the PHP, if the Division member no longer resides in the PHP's Service Area. Division members shall be disenrolled if out of the PHP's Service Area for more than three (3) months, unless previously arranged with the PHP. The effective date of disenrollment shall be the date specified by the Division and the Division shall recoup the balance of that month's Capitation Payment from the PHP;

(G) The Division member is an inmate who is serving time for a criminal offense or confined involuntarily in a State or Federal prison, jail, detention facility, or other penal institution. This does not include Division members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the Division members and providing sufficient proof of incarceration to HMU for review of the disenrollment request. The Division shall approve requests for disenrollment from PHPs for Division members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHPs are responsible for inpatient services only during the time a Division member was an inmate;

(H) The Division member is in a state psychiatric institution.

(4) The Division Initiated disenrollments:

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

(A) If the Division determines that the Division member has sufficient third party resources such that health care and services may be cost effectively provided on a FFS basis, the Division may disenroll the Division member. The effective date of disenrollment shall be the end of the month in which the Division makes such a determination. The Division may specify a retroactive effective date of disenrollment if the Division member's third party coverage is through the PHP or in other situations agreed to by the PHP and the Division;

(B) If the Division member moves out of the PHP's Service Area, the effective date of disenrollment shall be the date specified by the Division and the Division shall recoup the balance of that month's Capitation Payment from the PHP;

(C) If the Division member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project or Children's Health Insurance Program, the effective date of disenrollment shall be the date specified by the Division;

(D) If the Division member dies, the effective date of disenrollment shall be through the date of death;

(E) When a non-Medicare contracting PHP is assumed by another PHP that is a Medicare Advantage plan, Division members with Medicare shall be disenrolled from the existing PHP. The effective date of disenrollment shall be the day prior to the month the new PHP assumes the existing PHP;

(b) Unless specified otherwise in these rules or in the Division notification of disenrollment to the PHP, all disenrollments are effective the end of the month after the request for disenrollment is approved by the Division;

(c) The Division shall inform the Division members of the disenrollment decision in writing, including the right to request an Administrative Hearing. OHP clients may request a Division hearing if they dispute a disenrollment decision by the Division;

(d) If the OHP client requests a hearing, the OHP client shall continue to be disenrolled until a hearing decision reversing that disenrollment is sent to the OHP client.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0085 – Health Plan Disenrollment from Primary Care Managers

(1) Primary Care Manager (PCM) member requests for disenrollment:

(a) All PCM member-initiated requests for disenrollment from PCM must be initiated by the primary person in the benefit group, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For PCM members who are not able to request disenrollment on their own, the request may be initiated by the PCM member's representative;

(b) Primary person or representative requests for disenrollment shall be honored:

(A) During the first 30 days of enrollment without cause. The effective date of disenrollment shall be the first of the month following PCM member notification to the Authority;

(B) After six months of PCM member's enrollment without cause. The effective date of disenrollment shall be the first of the month following PCM member notification to the Oregon Health Authority (Authority);

(C) Whenever a PCM member's eligibility is re-determined by the Authority and the primary person requests disenrollment without cause. The effective date of disenrollment shall be the first of the month following the date that PCM member's eligibility is re-determined by the Authority;

(D) At any other time with cause:

(i) The Division of Medical Assistance Programs (Division) shall determine if sufficient cause exists to honor the request for disenrollment;

(ii) Examples of sufficient cause include but are not limited to:

(I) The PCM member moves out of the PCM service area;

(II) It would be detrimental to the PCM member's health to remain enrolled with the PCM;

(III) The PCM member is a Native American or Alaskan Native with proof of Indian heritage who wishes to obtain primary care services from his or her Indian Health Service facility, Tribal Health clinic/program or urban clinic and the fee-for-service delivery system.

(c) In addition to the disenrollment constraints listed in subsection (b) of this section, PCM member disenrollment requests are subject to the following requirements:

(A) The PCM member shall select another PCM or Prepaid Health Plan, unless the PCM member resides in a service area where enrollment is voluntary;

(B) If the only PCM or Prepaid Health Plan available in a PHP, PHP/ PCM or PCM mandatory service area is the PCM from which the PCM member wishes to disenroll, the PCM member may not disenroll without cause.

(2) PCM requests for disenrollment:

(a) Procedures for PCM requests for disenrollment are as follows:

(A) Requests by the PCM for disenrollment of specific PCM members shall be submitted in writing to the Division for approval prior to disenrollment. The PCM shall document the reason for the request, provide other records to support the request, and certify that the request is not due to an adverse change in the PCM member's health. If the situation warrants, the Division shall consider an oral request for disenrollment, with written documentation to follow, the Division shall approve PCM requests for disenrollment that meet the Division criteria;

(B) The Division shall respond to PCM requests in a timely manner and in no event greater than 30 calendar days;

(C) The PCM shall not disenroll or request disenrollment of any PCM member because of an adverse change in the PCM member's health.

(b) The Division may disenroll PCM members for cause when requested by the PCM:

(A) The Division shall inform the PCM member of:

(i) An approved disenrollment decision;

(ii) Any requirement to select another PCM;

(iii) Right to request a Division hearing if the disenrollment decision by the Division is disputed.

(B) Examples of cause include, but are not limited to the following:

(i) The PCM member refuses to accept medically appropriate treatment and/or follow Medically Appropriate guidelines;

(ii) The PCM member is unruly or abusive to others or threatens or commits an act of physical violence directed at a medical provider, the provider's staff or other patients;

(iii) The PCM member has permitted the use of his or her Medical Care Identification by another person or used another person's Medical Care Identification;

(iv) The PCM member has missed three appointments without canceling and/or without explanation and the PCM has documented attempts to accommodate the PCM member's needs and to counsel with or educate the PCM member.

(c) If the Division approves the PCM request for disenrollment of a PCM member because the PCM member is abusive to others or threatens or commits an act of physical violence, the following procedures shall apply:

(A) The Division shall inform the PCM member of the disenrollment decision;

(B) The PCM member shall be disenrolled. All PCM members in the PCM member's benefit group, as defined in OAR 461-110-0720, may be disenrolled;

(C) The effective date of disenrollment shall be the date of the PCM's request for disenrollment;

(D) The Division shall require the PCM member and/or the benefit group to obtain services from fee-for-service providers for six months;

(E) After six months the PCM member and/or the benefit group shall be required to select another PCM, if available in the service area;

(F) The Division shall notify the new PCM that the PCM member and/or benefit group was previously disenrolled from another PCM at the PCM's request.

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

(a) If the Division determines the PCM member has third party resources through a private HMO, the Division may disenroll the PCM member. The effective date of disenrollment shall be specified by the Division and shall be the first of the month after the Division determines the PCM member should be disenrolled;

(b) If the PCM member moves out of the PCM's service area, the effective date of disenrollment shall be the date specified by the Division, which may be retroactive up to one month prior to the month the Division notifies the PCM;

(c) If the PCM member is no longer eligible under the Oregon Health Plan (OHP) Medicaid Demonstration Project, the effective date of disenrollment shall be the date specified by the Division;

(d) If the PCM member dies, the effective date of disenrollment shall be through the date of death.

(4) Unless specified otherwise in this rule or at the time of notification of disenrollment to the PCM by the Division all disenrollments are effective the first of the month after the request for disenrollment is approved by the Division.

(5) OHP clients may request a Division hearing if they dispute a disenrollment decision by the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0120 – Managed Care Prepaid Health Plan Provision of Health Care Services

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and ancillary services, and in those categories of services included in contract or agreements with the Division of Medical Assistance Programs (Division) and Addictions and Mental Health (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all participating providers providing covered services to Division members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination based on the requirements of the discipline or profession that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges, and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities including oversight of the following processes:

(A) PHPs shall ensure that covered 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 and that participating providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, Oregon Health Plan (OHP) administrative rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and shall provide accurate and timely information about license or certification expiration and renewal dates to the Division. PHPs may not refer Division members to or use providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or certification is expired or

not renewed or is subject to licensing or certification sanction, the PHP shall immediately notify the member's Provider Services Unit.

(D) PHPs may not refer members to or use providers who have been terminated from the Division or excluded as Medicare and Medicaid providers by Centers for Medicare and Medicaid (CMS) or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs may not accept billings for services to members provided after the date of such provider's exclusion, conviction, or termination. The Oregon Health Authority (Authority) has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they shall submit to their Coordinated Care Account Representative (CAR) for Authority approval prior to use. PHPs shall obtain information required on the appropriate disclosure form from individual practitioners and entities and shall retain the disclosure statements in the PHP credential files. If a PHP 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 contender"), the PHP shall immediately notify the Division's Provider Services Unit.

(E) PHPs shall obtain and use the Division's provider enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number "999999" may no longer be used in encounter data reporting or provider capacity reporting. PHPs shall require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).

(F) The provider enrollment request (for encounter purposes) and disclosure statement described in paragraphs (D) and (E) require the disclosure of taxpayer identification numbers. The taxpayer identification number will be used for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, administration of tax laws, and may be used 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), and the Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification number(s) may result in denial of enrollment as a provider, denial of a provider number for encounter purposes, denial of continued enrollment as a provider, and deactivation of all provider numbers used by the provider for encounters.

(b) FCHPs, Physician Care Organization (PCOs), and Dental Care Organizations (DCOs) shall have written procedures that provide newly enrolled members with information about which participating providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, and DCOs shall have written procedures that allow and encourage a choice of a Primary Care Provider (PCP) or clinic for physical health and dental health services by each member. These procedures shall enable a member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that member;

(d) If the member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO shall ensure the member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign members to PCPs or clinics shall document the unsuccessful efforts to elicit the member's choice before assigning a member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after enrollment shall notify the member of the assignment and allow the member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to the member's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) The following services may be received by Division members from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), the member is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and planning committees;

(e) FCHPs and PCOs shall report to the Division on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled member receives timely, adequate, and appropriate health care services necessary to establish and maintain the health of the member. An FCHP's liability covers the period between the member's enrollment and disenrollment with the FCHP, unless the member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the member's PCP or designated practitioner determines the care is no longer medically appropriate.

(4) A PCO's liability covers the period between the member's enrollment and disenrollment with the PCO, unless the member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of the Division.

(5) The member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services and shall coordinate benefits for shared members to ensure that the member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible member is enrolled in a FCHP or PCO with a Medicare HMO component, the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health or dental care for that member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer members to the divisions of the Authority and local and regional allied agencies that may offer services not covered under the capitation payment;

(c) FCHPs and PCOs may not require members to obtain the approval of a PCP in order to gain access to mental health and Substance Use Disorder assessment and evaluation services. Division members may refer themselves to MHO services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 192.518 - 192.526, 556.320, 414.065, 414.727, and 441.223

410-141-0140 – Oregon Health Plan Prepaid Health Plan (PHP) Emergency and Urgent Care Services

(1) PHPs shall have written policies and 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 Division of Medical Assistance Programs (Division) members. PHPs 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 participating provider's compliance. PHPs shall document all monitoring and corrective action activities.

(2) PHPs shall have written policies and procedures and monitoring processes to ensure that a practitioner provides a medically or dentally appropriate response as indicated to urgent or emergency calls consisting of the following elements:

(a) Telephone or face-to-face evaluation of the Division member to determine the nature of the situation and the Division member's immediate need for services;

(b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilizing the urgent or emergency situation;

(c) Development of a course of action at the conclusion of the assessment;

(d) Provision of services and/or referral needed to address the urgent or emergency situation, begin post-stabilization care or provide outreach services in the case of a Mental Health Organization (MHO);

(e) Provision for notifying a referral emergency room, when applicable concerning the presenting problem of an arriving Division member, and whether or not the practitioner will meet the Division member at the emergency room; and

(f) Provision for notifying other providers requesting approval to treat Division members of the determination.

(3) PHPs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from Division members. Urgent calls shall be returned appropriate to the Division 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 call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.

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

(a) The PHP 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-emergency in nature;

(b) The PHP may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The PHP may not deny a claim for emergency services merely because the primary care physician (PCP) was not notified, or because the PHP was not billed within 10 calendar days of the service.

(5) When a Division member's primary care provider, designated practitioner or other health plan representative instructs the Division member to seek emergency care, in or out of the network, the PHP is responsible for payment of the screening examination and for other medically appropriate services. Except as otherwise provided in (6) of this rule, the PHP is responsible for payment of post-stabilization care that was:

(a) Pre-authorized by the PHP;

(b) Not pre-authorized by the PHP if the PHP (or the on-call provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PHP or Provider on call could not be contacted; or

(c) If the PHP and the treating physician cannot reach an agreement concerning the Division member's care and a PHP representative is not available for consultation, the PHP must give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with care of the patient until a PHP physician is reached or one of the following criteria is met:

(A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;

(B) The participating provider assumes responsibility for the Division member's care through transfer;

(C) A contractor representative and the treating physician reach an agreement concerning the Division member's care; or

(D) The Division member is discharged.

(6) Physician Care Organization (PCO) responsibility with regard to emergency services, urgent care services, or post stabilization care services is as follows:

(a) A PCO is not financially responsible for emergency services, urgent care services, or post stabilization services, to the extent such services are inpatient hospital services. The PCO shall not authorize, cause, induce or otherwise furnish any incentive for emergency services, urgent care services, or post stabilization services to be rendered as inpatient hospital services except to the extent medically appropriate.

(b) A PCO is financially responsible for post stabilization services (other than inpatient hospital services) obtained by Division members within or outside the PCO's network under the following circumstances:

(A) Post stabilization services have been authorized by the PCO's authorized representative;

(B) Post stabilization services have not been authorized by the PCO's authorized representative, but are administered to maintain the Division member's stabilized condition within 1 hour of a request to the PCO's authorized representative for approval of further post stabilization services;

(C) Post stabilization services have not been authorized by the PCOs authorized representative, but are administered to maintain, improve, or resolve the Division member's stabilized condition if:

(i) The PCO's authorized representative does not respond to a request for authorization within 1 hour;

(ii) The PCO's authorized representative cannot be contacted; or

(iii) The PCO's authorized representative and the treating physician cannot reach an agreement concerning the Division member's care and the participating provider is not available for consultation. In this situation, the PCO must give the treating physician the opportunity to consult with the participating provider and the treating physician may continue with the care of the Division member until the participating provider is reached or one of the criteria in section (6) of this rule has been met.

(c) The PCO's financial responsibility for non-Inpatient post-stabilization services it has not approved ends when:

(A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;

(B) The participating provider assumes responsibility for the Division member's care through transfer;

(C) A PCO representative and the treating physician reach an agreement concerning the Division member's care; or

(D) The Division member is discharged.

(7) PHPs shall have methods for tracking inappropriate use of emergency care and shall take action, individual Division member counseling, to improve appropriate use of urgent and emergency care settings. DCOs and MHOs shall be responsible for taking action to improve appropriate use of urgent and emergency care settings for dental or mental health related care when inappropriate use of emergency care is made known to them through reporting or other mechanisms.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0160 – Oregon Health Plan Prepaid Health Plan Coordination and Continuity of Care

(1) Prepaid Health Plans (PHPs) shall have written policies, procedures, and monitoring systems that ensure the provision of Medical Case Management Services, delivery of primary care to and coordination of health care services for all Division members:

(a) PHPs are to coordinate and manage capitated services and non-capitated services, and ensure that referrals made by the PHP's providers to other providers for covered services are noted in the appropriate Division of Medical Assistance Program (Division) member's clinical record;

(b) PHPs shall ensure Division members receiving Exceptional Needs Care Coordination (ENCC) services for the aged, blind or disabled who have complex medical needs as described in 410-141-0405, are noted in the appropriate Division member’s record. ENCC is a service available through Fully Capitated Health Plans (FCHPs) or Physician Care Organizations (PCOs) that is separate from and in addition to medical case management services;

(c) These procedures must ensure that each Division member has an ongoing source of primary care appropriate to his or her needs and a Practitioner or entity formally designated as primarily responsible for coordinating the health care services furnished to the Division member in accordance with OAR 410-141-0120;

(d) FCHPs and PCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures and take any corrective action necessary to ensure provider compliance. FCHPs and PCOs shall document all monitoring and corrective action activities:

(A) PHPs shall develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable alternative care settings, for all services covered by contracts/agreements with the Division and/or Addictions and Mental Health Division (AMH) formerly known as Office of Mental Health and Addictions Services (OMHAS). PHPs shall ensure that access to and quality of care provided in all referral settings is monitored. Referral services and services received in alternative care settings shall be reflected in the Division member's clinical record. PHPs shall establish and follow written procedures for participating and non-participating providers in the PHP's referral system. Procedures shall include the maintenance of records within the referral system sufficient to document the flow of referral requests, approvals and denials in the system;

(B) The Division member shall obtain all covered services, either directly or upon referral, from the PHP or Primary Care Manager (PCM) responsible for the service from the date of enrollment through the date of disenrollment, except

when the Division member is enrolled in a Medicare Health Maintenance Organization (HMO) or Medicare Advantage FCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or Medicare Advantage and MHOs have significant and shared responsibility for prepaid services, and shall coordinate benefits for the Division member to ensure that the Division member receives all medically appropriate services covered under respective capitation payments;

(ii) If the Division member is enrolled in a FCHP or PCO with a Medicare HMO component or Medicare Advantage, then Medicare covered mental health services shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO, respectively. Mental health services that are not covered by the FCHP or PCO, but are covered by the Mental Health Organization (MHO), shall be obtained from the MHO or upon referral by the MHO.

(C) PHPs shall have written procedures for referrals which ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the Division member's clinical record;

(D) PHPs shall designate a staff member who is responsible for the arrangement, coordination and monitoring of the PHP's referral system;

(E) PHPs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional;

(F) PHPs shall have written procedures that ensure that relevant medical, mental health, and/or dental information is obtained from referral providers, including telephone referrals. These procedures shall include:

(i) Review of information by the referring provider;

(ii) Entry of information into the Division member's clinical record;

(iii) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral providers, reviewed by the referring practitioner, and entered into the clinical record.

(G) PHPs shall have written procedures to orient and train their staff, participating practitioners and their staff, and the staff in alternative care settings, and urgent and emergency care facilities in the appropriate use of the PHP's referral, alternative care, and urgent and emergency care systems. Procedures and education shall ensure use of appropriate settings of care;

(H) PHPs shall have written procedures which ensure that an appropriate staff person responds to calls from other providers requesting approval to provide care to Division members who have not been referred to them by the PHP. If the person responding to the call is not a health care professional, the PHP shall have established written protocols that clearly describe when a health care professional needs to respond to the call. These procedures and protocols shall be reviewed by the PHP for appropriateness. The procedures shall address notification of acceptance or denial and entry of information into the PCP's clinical record;

(I) FCHPs and PCOs shall have written policies and procedures to ensure information on all emergency department visits is entered into the Division member's appropriate PCP's clinical record. FCHPs and PCOs shall communicate this policy and procedure to providers, monitor providers' compliance with this policy and procedure, and take corrective action necessary to ensure compliance;

(J) If a Division member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:

(i) A notation is made in the Division member's appropriate PCP's clinical record of the reason, date, and expected duration of the hospitalization;

(ii) Upon discharge, a notation is made in the Division member's appropriate PCP's clinical record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and

(iii) Pertinent reports from the hospitalization are entered in the Division member's appropriate PCP's clinical record. Such reports shall include, as applicable, the reports of consulting practitioners physical history, psycho-social history, list of medications and dosages, progress notes, and discharge summary.

(2) For Division members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure that the Division member has timely and appropriate access to covered services and to ensure coordination of care provided by the PHP and care provided by the facility or home. PHPs shall make provisions for a PCP or the facility's "house doctor or dentist" to provide care to Division members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For Division members living in residential facilities or homes providing ongoing care, FCHPs and PCOs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs and PCOs shall provide emergency prescriptions on a 24hour basis.

(4) For Division members who are discharged to post hospital extended care, the FCHP shall notify the appropriate Department office at the time of admission to the skilled nursing facility (SNF) and begin appropriate discharge planning. The FCHP is not responsible for the post hospital extended care benefit unless the Division member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the Division member no later than two full working days prior to discharge from post hospital extended care. For Division members who are discharged to medicare skilled care, the appropriate DHS office shall be notified at the time the FCHP learns of the admission. The FCHP shall initiate appropriate discharge planning at the time of the notification to the Department office.

(5) PHPs shall coordinate the services the PHP furnishes to Division members with the services the Division member receives from any other PHP (FCHP, PCO, Dental Care Organization (DCO) or MHO) in accordance with OAR 410-141-0120 (6). PHPs shall ensure that in the process of coordinating care, each Division member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.

(6) When a Division member's care is being transferred from one PHP to another or for OHP clients transferring from fee-for-service to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the OHP client into the care of a PHP participating provider.

(7) PHPs shall make attempts to contact targeted Division population(s) by mail, telephone, in person or through the Oregon Health Authority (Authority) within the first three months of enrollment to assess medical, mental health or dental needs, appropriate to the PHP. The PHP shall, after reviewing the assessment, refer the Division member to his/her PCP or other resources as indicated by the assessment. Targeted Division population(s) shall be determined by the PHP and approved by the Division.

(8) MHOs shall establish working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area for the purposes of maintaining a comprehensive and coordinated mental health delivery system and to help ensure Division member access to mental health services which are not provided under the capitation payment.

(9) MHOs shall ensure that Division members receiving services from extended or long term psychiatric care programs (e.g., secure residential facilities, PASSAGES projects, state hospital) will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.

(10) MHOs shall coordinate with community emergency service agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to Division members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for Division members requiring services from more than one public agency. This approach shall help avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive treatment setting (e.g., clinic, home, school, community).

(12) MHOs shall consult with, and provide technical assistance to, FCHPs and PCOs to help assure that mental health conditions of Division members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0180 – Oregon Health Plan Prepaid Health Plan Record Keeping

(1) Maintenance and Security: Prepaid Health Plans (PHPs) 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 care received by the members from the PHP's primary care and referral providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's participating providers shall have written policies and procedures to ensure that clinical records related to the member's individual identifiable health information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50, and section (3) of this rule. If the PHP is a public body within the meaning of the Oregon public records law, the policies and procedures shall ensure that member privacy is maintained in accordance with 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their participating providers may not release or disclose any information concerning a member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the member;

(b) Except in an emergency, PHPs' participating providers shall obtain a written authorization for release of information from the member or the legal guardian or the member's legal Power of Attorney for Health Care Decisions before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information and shall be placed in the member's record. In an emergency, release of service information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the member;

(c) PHPs may consider a member age 14 or older competent to authorize or prevent disclosure of mental health and substance use disorder treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the member's clinical treatment requirements.

(3) Exchange of Protected Health Information for Treatment Purposes without Authorization: In accordance with ORS 192.518 to 192.526 and with required acknowledgement, the Authority and PHP's may share the following protected health information without member authorization for the purpose of treatment activities. The protected health information that may be disclosed, commonly found in claims or encounters, includes the following:

(a) Oregon Health Plan member name;

(b) Medicaid recipient number;

(c) Performing provider number;

(d) Hospital provider name and attending physician name;

(e) Diagnosis;

(f) Dates of service;

(g) Procedure code;

(h) Revenue code;

(i) Quantity of units of service provided;

(j) Medication prescription and monitoring;

(4) Access to clinical records:

(a) Provider access to clinical records:

(A) PHPs shall release health service information requested by a provider involved in the member's care within ten working days of receiving a signed authorization for release of information;

(B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service providers, have access to the applicable contents of a member's mental health record when necessary for use in the member's diagnosis or treatment. Such access is permitted under ORS 179.505(6);

(b) Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' participating providers shall upon request, provide the member access to their own clinical record, allow for the record to be amended or corrected, and provide copies within ten working days of the request. PHPs' participating providers may charge the member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' participating providers shall upon receipt of a member's written authorization for release of information, provide access to the member's clinical record. PHPs' participating providers may charge for reasonable duplication costs;

(d) Authority Access to Records: PHPs shall cooperate with the Division, the Addictions and Mental Health Division (AMH), the Medicaid Fraud Unit, and AMH representatives for the purposes of audits, inspection, and examination of members' clinical and administrative records.

(5) Retention of Records: 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 shall be retained until all issues arising out of the action are resolved.

(6) Requirements for Clinical Records: PHPs shall have policies and procedures that ensure maintenance of a clinical record keeping system that is consistent with state and federal regulations to which the PHP is subject. The system shall assure accessibility, uniformity, and completeness of clinical information that fully documents the member's condition and the covered and non-covered services received from PHPs' participating or referred providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PHPs shall document all monitoring and corrective action activities:

(a) A clinical record shall be maintained for each member receiving services that documents all types of care needed or delivered in all settings whether services are delivered during or after normal clinic hours;

(b) All entries in the clinical record shall be signed and dated;

(c) Errors to the clinical record shall be corrected as follows:

(A) Incorrect data shall be crossed through with a single line;

(B) Correct and legible data shall be added followed by the date corrected and initials of the individual making the correction;

(C) Removal or obliteration of errors shall be prohibited;

(d) The clinical record shall reflect a signed and dated authorization for treatment for the member, his or her legal guardian, or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's or clinic's clinical record shall include data that forms the basis of the diagnostic impression of the member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's member's clinical record receiving services shall include the following information as applicable:

(A) Member name, date of birth, sex, address, telephone number, and identifying number as applicable;

(B) Name, address, and telephone number of next of kin, legal guardian, Power of Attorney for Health Care Decisions, or other responsible party;

(C) Medical, dental, or psychosocial history as appropriate;

(D) Dates of service;

(E) Names and titles of individuals performing the services;

(F) Physicians' orders;

(G) Pertinent findings on examination and diagnosis;

(H) Description of medical services provided including medications administered or prescribed; tests ordered or performed, and results;

(I) Goods or supplies dispensed or prescribed;

(J) Description of treatment given and progress made;

(K) Recommendations for additional treatments or consultations;

(L) Evidence of referrals and results of referrals;

(M) Copies of the following documents if applicable:

(i) Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations, or evaluations;

(ii) Plans of care including evidence that the member was jointly involved in the development of the mental health treatment plan;

(iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;

(iv) Emergency department and screening services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided;

(N) Copies of signed authorizations for release of information forms;

(O) Copies of medical and mental health directives;

(f) Based on written policies and procedures, the clinical record keeping system developed and maintained by PHPs' participating providers shall include sufficient detail and clarity to permit internal and external clinical audit 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 for follow up treatment;

(g) The PCP or clinic shall have policies and procedures that accommodate members requesting to review and correct or amend their clinical record;

(h) PHPs' shall maintain other records in either the clinical record or within the PHP's administrative offices. Other records shall include the following:

(A) Names and phone numbers of the member's prepaid health plans, primary care physician or clinic, primary dentist, and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) also known as Measures and Outcomes Tracking System (MOTS) enrollment forms in the MHO's records;

(C) Copies of long-term psychiatric care determination request forms in the MHO's records;

(D) Evidence that the member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's or PCO's records;

(G) Complaint and Appeal records; and

(H) Disenrollment requests for cause and the supporting documentation.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.651

410-141-0200 – Oregon Health Plan Prepaid Health Plan Quality Improvement System

(1) QI Program:

(a) Fully Capitated Health Plans (FCHPs), Physician Care Organizations (PCOs) and Dental Care Organizations (DCOs) shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division members. This process shall include an internal QI Program based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with relevant law and the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards. The QI program shall include policies, standards, and written procedures that adequately address the needs of Division of Medical Assistance Program (Division) Members, including those who are aged, blind or disabled who have complex medical needs; or children receiving Children Adults and Families (CAF) State Office for Services to Children and Families (SOSCF) or Oregon Youth Authority (OYA) services. FCHPs, PCOs, DCOs and CDOs shall establish or adopt written criteria to monitor and evaluate the provision of adequate medical and/or dental care. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(b) Mental Health Organizations (MHOs) shall abide by the Quality Assurance Requirements as stated in the MHO Agreement.

(2) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. FCHPs, PCOs, DCOs and CDOs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The Quality Improvement Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Division members including those who are aged, blind or disabled who have complex medical needs and children receiving CAF (SOSCF) or OYA services, or shall be able to retain consultation from individuals who are qualified.

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

(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through

the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings;

(b) Conduct and submit to the Division an annual written evaluation of the QI Program and of the Division member care as measured against the written procedures and protocols of the Division member care. The evaluation of the QI program and the Division member care is to include a description of completed and ongoing QI activities, The Division member education and an evaluation of the overall effectiveness of the QI program. This evaluation shall include:

(A) Prevention programs;

(B) Care of Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services, and FCHP or PCO review of the Quality of Exceptional Needs Care Coordination program;

(C) Disease management programs;

(D) Adverse outcomes of Division members and Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services;

(E) Actions taken by the FCHPs, PCOs, DCOs or CDOs to address health care concerns identified by Division members or their Representatives and changes which impact quality or access to care. This may include: clinical record keeping; utilization review; referrals; comorbidities; prior authorizations; Emergency Services; out of FCHPs, PCOs, DCOs or CDOs utilization; medication review; FCHPs, PCOs, DCOs or CDOs initiated disenrollments; encounter data management; and access to care and services.

(c) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant Division member complaints and appeals;

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

(4) FCHPs or PCOs that are NCQA accredited or accredited by other Division recognized accreditation organizations shall be deemed for Section (3)(b) of this rule. FCHPs and PCOs deemed by the Division shall annually submit to the Division an evaluation of the Exceptional Needs Care Coordination program; and an evaluation of Division Member care for Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services. Copies of accreditation reports shall be submitted to the Division within 60 days of issuance.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0220 – Managed Care Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all Division of Medical Assistance Program (Division) members. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure participating provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between Division members and non-Division members as it relates to benefits and covered services to which they are both entitled:

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

(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.

(b) PHPs shall maintain and monitor a network of appropriate participating providers sufficient to ensure adequate service capacity to provide availability of, and timely access to, medically appropriate covered services for Division members:

(A) PHPs 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;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to Division members in terms of timeliness, amount, duration and scope as those services are to non-Division persons within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to the Division and shall provide reasonable alternatives for Division members to access care that must be approved by the Division. PHPs shall have a monitoring system that will demonstrate to the Division or AMH, as applicable, that the PHP has surveyed and monitored for equal access of Division members to referral providers pharmacy, hospital, vision and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that Division members who are aged, blind, or disabled who have complex medical needs or who are children receiving Children Adults and Families (CAF) State Office for Services to Children and Families (SOSCF services) or Oregon Youth Authority (OYA) services have access to primary care, dental care, mental health providers and referral, as applicable. These providers shall have the expertise to treat, take into account and accommodate the full range of medical, dental or mental health conditions experienced by these Division members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs and Primary Care Managers (PCMs) enrollment standards:

(a) PHPs and PCMs shall remain open for enrollment unless the Oregon Health Authority (Authority) has closed enrollment because the PHP or PCM has exceeded their enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by the Division or Addictions and Mental Health (AMH), as appropriate, and the PHP or PCM;

(b) PHPs enrollment may also be closed by the Division or AMH, as appropriate due to sanction provisions;

(c) PHPs and PCMs shall accept all Oregon Health Plan (OHP) clients, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with DHS to provide covered services or Primary Care management services;

(d) PHPs and PCMs may confirm the enrollment status of an OHP client by one of the following:

(A) The individual's name appears on the monthly or weekly enrollment list produced by the Division;

(B) The individual presents a valid medical care identification that shows he or she is enrolled with the PHP or PCM;

(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the PHP or PCM;

(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the PHP or PCM.

(e) PHPs shall have open enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, Division members shall be automatically enrolled in the succeeding PHP. The Division member will have 30 calendar days to request disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those Division members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding PHP.

(4) If a PHP engages in an activity, such as the termination of a participating provider or participating provider group which has significant impact on access in that service area and necessitates either transferring Division members to other providers or the PHP withdrawing from part or all of a service area, the PHP shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:

(a) A PHP may provide less than the required 90 calendar days notice to the Authority upon approval by the Authority when the PHP must terminate a participating provider or participating provider group due to problems that could compromise Division member care, or when such a participating provider or participating provider group terminates its contract with the PHP and refuses to provide the required 90 calendar days notice;

(b) If the Authority must notify Division members of a change in participating providers or PHPs, the PHP shall provide the Authority with the name, prime number, and address label of the Division members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide Division members with at least 30 calendar-days notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of Division member appointments are appropriate to the reasons for, and urgency of, the visit:

(a) PHPs shall have written policies and procedures and a monitoring system to assure that Division members have access to appointments according to the following standards:

(A) Fully Capitated Health Plans (FCHPs) and PCOs:

(i) Emergency Care -- The Division member shall be seen immediately or referred to an emergency department depending on the Division member's condition;

(ii) Urgent Care -- The Division member shall be seen within 48 hours or as indicated in initial screening, in accordance with OAR 410-1410140; and

(iii) Well Care -- The Division member shall be seen within 4 weeks or within the community standard.

(B) Dental Care Organizations (DCOs):

(i) Emergency Care -- The Division member shall be seen or treated within 24-hours;

(ii) Urgent Care -- The Division member shall be seen within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(iii) Routine Care –The Division member shall be seen for routine care within an average of eight (8) weeks and within twelve (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.

(C) Mental Health Organizations (MHOs):

(i) Emergency Care -- Division member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care -- Division member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care -- Division member shall be seen for an intake assessment within 2 weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of Division members through the office such that Division members are not kept waiting longer than non-Division member patients, under normal circumstances. If Division members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, Division members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through complaint and appeal reviews, Division termination reports, and Division member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with Division member(s) when participating providers have notified the PHP that the Division member(s) have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed medically or dentally appropriate, documentation in the clinical record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the Division member's diagnosis or disability or is due to lack of transportation to the PHP’s participating provider office or clinic, PHPs shall provide outreach services as medically appropriate;

(d) PHPs shall have policies and procedures that ensure participating providers will attempt to contact Division members if there is a need to cancel or reschedule the Division member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to triage the service needs of Division members who walk into the PCP's office or clinic with medical, mental health or dental care needs. Such triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) Division members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the Division member's needs or be evaluated for treatment within two hours by a medical, mental health or dental provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by the Division and/or AMH because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics, as an operative element of FCHP's and PCO's after hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate clinical record of the Division member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental provider must be consulted. When medically appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the Division member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's participating providers) have sufficient

communication skills and training to reassure Division members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired Division members via Telecommunications Devices for the Deaf (TDD)/Tele Typewriter (TTY);

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's quality improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours, including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with, and providing care to Division 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) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of Division member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health or dental care visits, including home health visits, to interpret for Division members with hearing impairment or in the primary language of non-English speaking Division members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the Division member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the Provider to be able to understand the Division member's complaint; to make a diagnosis; respond to Division member's questions and concerns; and to communicate instructions to the Division member;

(c) PHPs shall ensure the provision of care and interpreter services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the Division member;

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

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether Division members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of Division members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all Division members including, but not limited to, the following:

(i) Street level access or accessible ramp into facility;

(ii) Wheelchair access to lavatory;

(iii) Wheelchair access to examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that participating providers, their facilities and personnel are prepared to meet the complex medical needs of Division members who are aged, blind or disabled:

(A) PHPs shall have a written plan for meeting the complex medical needs of Division members who are aged, blind or disabled;

(B) PHPs shall monitor participating providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-141-0260 – Managed Care Prepaid Health Plan Complaint or Grievance and Appeal Procedures

(1) Definitions:

(a) Action -- In the case of a Prepaid Health Plan (PHP):

(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 Division member in a single PHP service area, the denial of a request to obtain services outside of the PHP's participating provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(b) Appeal -- A request by a Division member or representative for review of an "action" as defined in this section;

(c) Complaint -- A Division member's or Division member's representative's expression of dissatisfaction to a PHP or to a practitioner about any matter other than an action, as "action" is defined in this section;

(d) Grievance System -- The overall system that includes a complaint process, an appeals process and access to the Division's administrative hearing process.

(2) The purpose of OAR 410-141-0260 through 410-141-0266 is to describe the requirements for the overall grievance system. These rules will apply to all PHPs as defined in 410-141-0000.

(3) All PHPs shall have written policies and procedures for a grievance system that ensures that they meet the requirements of sections OAR 410141-0260 to 410-141-0266.

(4) Information provided to the Division member shall include at least:

(a) Written material describing the PHP's complaint and appeal procedures, and how to make a complaint or file an appeal; and

(b) Assurance in all written, oral, and posted material of Division member confidentiality in the complaint and appeal processes.

(5) A Division member or a Division member's representative may file a complaint and a PHP level appeal orally or in writing, and may request a Division administrative hearing.

(6) PHPs shall keep all information concerning a Division member's complaint or appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

(7) Consistent with confidentiality requirements, the PHP's staff person who is designated to receive complaints or appeals, shall begin to obtain documentation of the facts concerning the complaint or appeal upon receipt of the complaint or appeal.

(8) PHPs shall afford Division members full use of the grievance system procedures. If the Division member decides to pursue a remedy through the Division's administrative hearing process, the PHP will cooperate by providing relevant information required for the hearing process.

(9) A request for a Division administrative hearing made to the Division outside of the PHP's appeal procedures, or without previous use of the PHP's appeal procedures shall be reviewed by the PHP through the PHP's appeal process upon notification by the Division as provided for in OAR 410-141-0264.

(10) Under no circumstances may a PHP discourage a Division member or a Division member's representative from using the Division's administrative hearing process.

(11) Neither implementation of a Division hearing decision nor a Division member's request for a hearing may be a basis for a request by the PHP for a Division member's disenrollment.

(12) PHPs shall make available a supply of blank complaint forms (OMAP 3001) in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals. PHPs shall make available a supply of blank Administrative Hearing Request forms (DHS 443) and the Notice of Hearing Rights forms (DMAP 3030). PHPs shall develop an appeal form and shall make the appeal forms, along with the DHS 443 and DMAP 3030 forms, available in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals.

(13) The PHP must provide information about the grievance system to all participating providers and subcontractors at the time they enter into a contract.

(14) The PHP must maintain logs that are in compliance with OAR 410141-0266 to document complaints and appeals received by the PHP, and the State must review the information as part of the State quality strategy.

Stat. Auth.: ORS 409.110, 413.042 and 414.065

Stats. Implemented: ORS 414.725

410-141-0261 – Prepaid Health Plan Grievance Procedures

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) A grievance (see definition) procedure applies only to those situations in which the (Division) member (see definition) or their representative (see definition) expresses concern or dissatisfaction about any matter other than an "action." Prepaid Health Plans (PHPs) shall have written procedures to acknowledge the receipt, disposition and documentation of each grievance from Division members. The PHP's written procedures for handling grievances, shall, at a minimum:

(a) Address how the PHP will accept, process and respond to each grievance from a Division member or their representative, including:

(A) Acknowledgment to the Division member or representative of receipt of each grievance;

(B) Ensuring that Division members who indicate dissatisfaction or concern are informed of their right to file a grievance and how to do so;

(C) Ensuring that each grievance is transmitted timely to staff having authority to act upon it;

(D) Ensuring that each grievance is investigated and resolved in accordance with these rules; and

(E) Ensuring that the practitioner(s) or staff person(s) who make decisions on the grievance must be persons who are:

(i) Not involved in any previous level of review or decision-making; and

(ii) Who are health care professionals who have appropriate clinical expertise in treating the Division member's condition or disease if the grievance concerns denial of expedited resolution of an appeal or if the grievance involves clinical issues:

(b) Describe how the PHP informs Division members, both orally and in writing, about the PHP's grievance procedures;

(c) Designate the PHP staff member(s) or a designee who will be responsible for receiving, processing, directing, and responding to grievances;

(d) Include a requirement for grievances to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(2) The PHP must provide Division members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a grievance. This includes, but is not limited to, providing interpreter services and toll free phone numbers that have adequate Tele Typewriter (TTY)/ Telecommunications Devices for the Deaf (TTD) and interpreter capabilities.

(3) The PHP shall assure Division members that grievances are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the grievance as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's grievance is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose services, items or quality of care is alleged to be involved in the grievance have a right to use this information for purposes of the PHP resolving the grievance, for purposes of maintaining the log required in OAR 410-1410266, and for health oversight purposes, without a signed release from the Division member;

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the grievance to other individuals as needed for resolution. Before any information related to the grievance is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the grievance file. Copies of the form for obtaining the release of information shall be included in the PHP's written process.

(4) The PHPs procedures shall provide for the disposition of grievances within the following timeframes:

(a) The PHP must resolve each grievance, and provide notice of the disposition, as expeditiously as the Division member's health condition requires, within the timeframes established in this rule;

(b) For standard disposition of grievances and notice to the affected parties, within 5 working days from the date of the PHP's receipt of the grievance, the PHP must either:

(A) Make a decision on the grievance and notify the Division member; or

(B) Notify the Division member in writing that a delay in the PHP's decision of up to 30 calendar days from the date the grievance was received by the PHP is

necessary to resolve the grievance. The PHP shall specify the reasons the additional time is necessary.

(5) The PHP's decision about the disposition of a grievance shall be communicated to the Division member orally or in writing within the timeframes specified in (4) of this rule:

(a) An oral decision about a grievance shall address each aspect of the Division member’s grievance and explain the reason for the PHP's decision;

(b) A written decision must be provided if the grievance was received in writing. The written decision on the grievance shall review each element of the Division member's grievance and address each of those concerns specifically, including the reasons for the PHP’s decision.

(6) All grievances made to the PHP’s staff person designated to receive grievances shall be entered into a log and addressed in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410141-0266.

(7) All grievances that the Division member chooses to resolve through another process, and that the PHP is notified of, shall be noted in the grievance log.

(8) Division members who are dissatisfied with the disposition of a grievance may present their grievance to the Governors Advocacy Office.

Stat. Auth.: ORS 409.110, 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-141-0262 – Prepaid Health Plan Appeal Procedures

(1) A Division of Medical Assistance Programs (Division) Member or their representative that disagrees with a Notice of Action may file a Prepaid Health Plan (PHP) level appeal or request a Division administrative hearing. Division members may not be required to go through a PHP level appeal in order to request a Division administrative hearing.

(2) The PHP must have a system in place for Division member which includes an appeal process when a Division member has requested a Division administrative hearing. For purposes of this rule, an appeal includes a request to the PHP for review of an Action upon notification from the Division.

(3) An appeal must be filed with the PHP no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263.

(4) If the Division member initiates an appeal directly with the PHP, it shall be documented in writing by the PHP and handled as an appeal consistent with this rule. The Division member or Division member's representative may file an appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed appeal.

(5) Each PHP must adopt written policies and procedures for handling appeals that, at a minimum, meet the following requirements:

(a) Give Division members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal or administrative hearings request. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Tele Typewriter (TTY)/ Telecommunications Devices for the Deaf (TTD) and interpreter capacity;

(b) Address how the PHP will accept, process and respond to such appeals, including how the PHP will acknowledge receipt of each appeal;

(c) Ensuring that Division members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an appeal and an administrative hearing request and how to do so;

(d) Ensuring that each appeal is transmitted timely to staff having authority to act on it;

(e) Ensuring that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensuring that the individuals who make decisions on appeals are individuals:

(A) Who were not involved in any previous level of review or decision making; and

(B) Who are health care professionals who have the appropriate clinical expertise in treating the Division member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues:

(g) Include a requirement for appeals to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(6) The PHP shall assure Division members that appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the appeal have a right to use this information for purposes of resolving the appeal and for purposes of maintaining the log required in OAR 410-141-0266 and for health oversight purposes by Division, without a signed release from the Division member. The administrative hearing regarding the appeal without a signed release from the Division member, pursuant to 410-120-1360(4);

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the appeal to other individuals. Before any information related to the appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the appeal file.

(7) The process for appeals must:

(a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the Division member or Division member's representative requests expedited resolution;

(b) Provide the Division member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the Division member or the Division member's representative of the limited time available in the case of an expedited resolution);

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

(d) Include as parties to the appeal the Division member, the Division member's representative, or the legal representative of a deceased Division member's estate.

(8) The PHP must resolve each appeal and provide a client notice of the appeal resolution as expeditiously as the Division member's health condition requires and within the time frames in this section:

(a) For the standard resolution of appeals and client notices to the Division member or Division member's representative, the PHP shall resolve the appeal and provide a client notice no later than 16 calendar days from the day the PHP receives the appeal.

(b) When the PHP has granted a request for expedited resolution of an appeal, the PHP shall resolve the appeal and provide a client notice no later than 3 working days after the PHP receives the appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(c) In accordance with 42 CFR 438.408, the PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:

(A) The Division member or Division members representative requests the extension; or

(B) The PHP shows (to the satisfaction of the Division's Hearings Unit upon its request) that there is need for additional information and how the delay is in the Division member's interest;

(d) If the PHP extends the timeframes, it must, for any extension not requested by the Division member, give the Division member or Division member's representative a written notice of the reason for the delay.

(9) For all appeals, the PHP must provide written Notice of Appeal Resolution to the Division member or their representative. If the PHP knows that there is a representative, the PHP must send a copy of the Notice to the representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.

(10) The written Notice of Appeal Resolution must be on a Division approved form and include the following:

(a) The results of the resolution process and the date it was completed; and

(b) For appeals not resolved wholly in favor of the Division member, the notice must also include the following information:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the PHP from the Division as part of an administrative hearings process, the right to request a Division Administrative Hearing, and how to do so, which includes attaching the appropriate forms as outlined in 410-141-0263;

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(D) That the Division member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.

(11) Unless the appeal was referred to the PHP as part of an administrative hearing process, a Division member may request a Division administrative hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution. The parties to the Division administrative hearing include the PHP as well as the Division member and/or Division member's representative, or the Representative of the deceased Division member's estate.

(12) Each PHP shall establish and maintain an expedited review process for appeals, consistent with OAR 410-141-0265.

(13) Each PHP shall maintain records of appeals, enter appeals and their resolution into a log, and address the appeals in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(14) Continuation of benefits pending appeal:

(a) As used in this section, "timely" filing means filing on or before the later of the following:

(A) Within 10 calendar days of the PHP mailing the Notice of Action; or

(B) The intended effective date of the PHP's proposed Action:

(b) The PHP must continue the Division member's benefits if:

(A) The Division member or Division member's representative files the appeal or administrative hearing request timely;

(B) The appeal or administrative hearing request involves the termination, suspension, or reduction of a previously authorized course of treatment;

(C) The services were ordered by an authorized provider;

(D) The original period covered by the original authorization has not expired; and

(E) The Division member or representative requests extension of benefits:

(c) Continuation of benefits pending administrative hearing — If, at the Division member's request, the PHP continues or reinstates the Division member's benefits while the appeal or administrative hearing is pending , the benefits must be continued pending administrative hearing pursuant to OAR 410-141-0264.

(15) If the final resolution of the appeal or administrative hearing is adverse to the Division member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the Division member while the appeal or administrative hearing was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

(16) If the PHP or a Division administrative hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the Division member's health condition requires.

(17) If the PHP or the Division administrative hearing decision reverses a decision to deny authorization of services, and the Division member received the disputed services while the appeal was pending, the PHP or the Division must pay for the services in accordance with the Division policy and regulations.

(18) If the appeal was referred to the PHP from the Division as part of an administrative hearing process, the PHP must immediately (within two business days) transmit the Notice of Appeal Resolution and the complete record of the appeal to the Division Hearings Unit.

(19) If the appeal was made directly by the Division member or Representative, and if the Notice of Appeal Resolution was not favorable to the Division member, the PHP must: Retain a complete record of the appeal for not less than 45 days so that, if an administrative hearing is requested, the record can be submitted to the Division's Hearings Unit within two business days of the Division's request.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0263 – Notice of Action by a Prepaid Health Plan

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) When a Prepaid Health Plan (PHP) or authorized practitioner (see definition) acting on behalf of the PHP takes or intends to take any “action,” including but not limited to denials or limiting prior authorizations of a requested service in an amount, duration or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other action, the PHP or authorized practitioner acting on behalf of the PHP shall mail a written client (see definition) Notice of Action (NOA) in accordance with section (2) of this rule to the Division member (see definition) within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be on a Division approved form and must be used for all denials of a requested service, reductions, discontinuations or terminations of previously authorized services, denials of claims payment or other action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the Division member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) The Division member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service;

(G) Effective date of the action, if different from the date of the NOA;

(H) Whether the PHP considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(b) The action the PHP or its participating provider (see definition) has taken or intends to take;

(c) Reasons for the action with enough specificity to clearly explain the actual reason for the denial, including but not limited to the following reasons:

(A) The item requires pre-authorization, and it was not pre-authorized;

(B) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(C) The person was not a Division member at the time of the service or is not a Division member at the time of a requested service; and

(D) The provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan rules);

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The Division member's right to file an appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The Division member's right to request a Division administrative hearing and how to exercise that right. A copy of the following forms must be attached to the Notice of Action:

(A) Hearing Request form (DHS 443) and the Notice of Hearing Rights (DMAP 3030), or

(B) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form DMAP 3302 or approved facsimile.

(g) The circumstances under which expedited appeal resolution is available and how to request it;

(h) The Division member's right to have benefits continue pending resolution of the appeal, how to request that benefit be continued and the circumstances under which the Division member may be required to pay the costs of these services; and

(i) The telephone number to contact the PHP for additional information.

(3) The PHP or practitioner acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension or reduction of previously authorized OHP covered services (see definition), the following time frames apply:

(A) The notice must be mailed at least ten calendar days before the date of action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP or authorized practitioner acting on behalf of the PHP may mail a notice not later than the date of action if:

(i) The PHP or practitioner receives a clear written statement signed by the Division member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The Division member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The Division member's whereabouts are unknown and the post office returns PHP or practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another state, territory, or commonwealth has accepted the Division member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the Division member's PCP or PCD; or

(vi) The date of action will occur in less than ten calendar days in accordance with 42 CFR 483.12(a)(5)(ii) related to discharges or transfers and long-term care facilities:

(C) The PHP may shorten the period of advance notice to five calendar days before the date of the action if the PHP has facts indicating that an action should be taken because of probable fraud by the Division member. Whenever possible, these facts should be verified through secondary sources:

(b) For denial of payment at the time of any action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the Division member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the Division member or the provider requests the extension or if the PHP justifies (to the Division upon request) a need for additional information and how the extension is in the Division member's interest;

(B) If the PHP extends the timeframe in accordance with subsection (A) of this section, it shall give the Division member written notice of the reason for the

decision to extend the timeframe and inform the Division member of their right to file a grievance if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the Division member's health condition requires and no later than the date the extension expires;

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section (which constitutes a denial and is thus an adverse action) on the date that the timeframes expire;

(e) For expedited prior authorizations within the timeframes specified in OAR 410-141-0265.

Stat. Auth.: ORS 409.110, 413.042, 414.065

Stats. Implemented: ORS 414.065

410-141-0264 – Contested Case Hearings

(1) An individual who is or was a Division member at the time of the notice of action is entitled to a contested case hearing if a Prepaid Health Plan (PHP) has denied requested services, payment of a claim, or terminates, discontinues or reduces a course of treatment, or any other action.

(a) If a member receives an adverse notice of action, the member may file a request for a contested case hearing. :

(b) If a member receives an adverse notice of appeal resolution from the PHP, the member may request a contested case hearing based on the notice of appeal resolution. :

(c) Contested case hearings are governed by OAR 410-120-1860, 410-120- 1865, and this rule.

(2) A written hearing request must be received by the Division not later than the 45th day following the date of the Notice of Action, or if the hearing request was initiated after an appeal, not later than the 45th day following the Notice of Appeal Resolution.

(3) 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 Division hearing requests.

(4) 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 (4)(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.

(5) The Division representative shall review the hearing request, documentation related to the hearing issue, and computer records to determine whether the claimant or the individual for whom the request is being made is or was a Division member at the time the action was taken, and whether the hearing request was timely.

(6) PHPs shall immediately transmit to the Division any hearing request submitted on behalf of a member, including a copy of the notice of action and, if applicable, notice of appeal resolution.

(7) If the member files a request for hearing with the Division, the Division shall send a copy of the hearing request to the PHP.

(8) PHPs shall review a hearing request, which has not been previously received or reviewed as an appeal, using the PHP's appeal process as follows:

(a) The appeal shall be reviewed immediately and shall be resolved, if possible, within 16 calendar days, pursuant to OAR 410-141-0262;

(b) The PHP shall provide the member with a written notice of appeal resolution.

(9) When a member requests a hearing, the PHP shall cooperate with providing relevant information required for the hearing process to the Division, as well as the results of the review by the PHP of the appeal and the administrative hearing request, and any attempts at resolution by the PHP.

(10) Information about members used for administrative hearings is handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The Division shall safeguard the member's right to confidentiality of information used in the hearing as follows:

(a) The Division, the member and their representative, the PHP and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the hearing may use this information for purposes of resolving the hearing without a signed release from the member. The Division may also use this information,

pursuant to OAR 410-120-1360(4), for health oversight purposes, and for other purposes authorized or required by law. The information may also be disclosed to the Office of Administrative Hearings and the Administrative Law Judge assigned to the hearing and to the Court of Appeals if the member seeks judicial review of the final order;

(b) Except as provided in subsection (a), the Division shall ask the member to authorize a release of information regarding the hearing to other individuals. Before any information related to the hearing is disclosed under this subsection, the Division must have an authorization for release of information documented in the hearing file.

(11) The hearings request and the notice of appeal resolution shall be referred to the Office of Administrative Hearings and the hearing will be scheduled.

(a) The parties to the hearing shall include the PHP, the member and his or her representative, or the representative of a deceased member's estate;

(b) The procedures applicable to the hearing shall be conducted consistent with OAR 410-120-1860 and 410-120-1865;

(c) A final order should be issued or the case otherwise resolved by the Division ordinarily within 90 calendar days from the earlier of the following:

(A) The date the member requested a PHP appeal, not including the number of days the member took to subsequently file a request for hearing or

(B) The date the member filed a request for contested case hearing.

(d) The final order is the final decision of the Division.

(12) If the hearing decision is adverse to the member, the PHP may recover the cost of the services furnished to the member while the hearing is pending, to the extent that they were furnished solely because of the requirements of this rule and in accordance with forth in 42 CFR 438.420.

(13) The PHP must promptly correct the action taken up to the limit of the original request or authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the member, or Division or the PHP decides in the member's favor before the hearing even if the member has lost eligibility after the date the action was taken:

(a) If the PHP, or a hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the hearing was pending, the PHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires;

(b) If the PHP, or the hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the hearing was pending, the PHP must pay for the services in accordance with Division policy and regulations in effect when the member requested the services.

Stat. Auth.: ORS 409.110 & 413.042

Stats. Implemented: ORS 414.065

410-141-0265 – Request for Expedited Appeal or Expedited Administrative Hearing

(1) Each PHP shall establish and maintain an expedited review process for appeals, when the PHP determines (upon request from the Division of Medical Assistance Programs (Division) member) or the provider indicates (in making the request on a Division member's behalf or supporting the DMAP member's request) that taking the time for a standard resolution could seriously jeopardize the Division member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Division member's appeal.

(3) If the PHP provides an expedited appeal, but denies the services or items requested in the expedited appeal, the PHP shall inform the Division member of the right to request an expedited Administrative Hearing and send the member a Division approved Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-0263 with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on appeal, it must:

(a) Transfer the appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A Division member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the Division member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to the Division's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. The Division's Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether the Division member is entitled to an expedited Administrative Hearing.

(7) If the Division's Medical Director denies a request for expedited Administrative Hearing, the Division must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

Stat. Auth.: ORS 409.110 & 413.042

Stats. Implemented: ORS 414.065

410-141-0266 – Prepaid Health Plan's Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The Prepaid Health Plans (PHP's) documentation shall include, at minimum, a log of all oral and written complaints and appeals received by the PHP. The log shall identify the Division of Medical Assistance Programs (Division) member and the following additional information:

(a) For complaints, the date of the complaint, the nature of the complaint, the disposition and date of disposition of the complaint;

(b) For appeals, the date of the Notice of Action, the date of the appeal, the nature of the appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the appeal;

(c) If an administrative hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the administrative hearing.

(2) The PHP shall also maintain a record for each of the complaints and appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the Division member. The PHPs shall retain documentation of complaints and appeals for seven years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the grievance system, including all complaints and appeals received by the PHP. The analysis of the grievance system shall be forwarded to the Quality Improvement Committee as necessary to comply with the quality improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of complaints and appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of complaints and appeals, and compliance with Oregon Health Plan rules.

Stat. Auth.: ORS 409.110 and 413.042

Stats. Implemented: ORS 414.065 and 442.807

410-141-0270 – Prepaid Health Plan Marketing Requirements for Potential Members

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

(a) “Cold-call Marketing” means any unsolicited personal contact with a potential member for the purpose of marketing by the PHP; Cold-call marketing methodologies may include, but are not limited to, door to door, telephone, mail, or e-mail.

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

(c) “Marketing Materials” means materials that are produced in any medium by or on behalf of a PHP and that can reasonably be interpreted as intended to market to potential members;

(d) “Outreach” means any communication from a PHP to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP. Outreach activities include, but are not limited to, the act of raising the awareness of the PHP, the PHP’s subcontractors and partners, the PHP contractually required programs and services, and the promotion of healthful behaviors, health education, and health related events.

(e) “Outreach Materials” means materials that are produced in any medium, by or on behalf of a PHP that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP.

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

(2) PHPs must comply with the information required in 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the PHP provides accurate oral and written information a potential member needs to make an informed decision on whether to enroll in that PHP. In so doing, the PHP must:

(a) Not distribute any marketing materials without first obtaining state approval;

(b) Distribute the materials to its entire service area as indicated in its PHP contract;

(c) Not seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance;

(d) Not directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The creation of name recognition shall not constitute an attempt by the PHP to compel or entice a client's enrollment and are expressly permitted. Communication methodologies may include, but are not limited to: brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(4) PHPs' or their subcontractor's communications that express participation in or support for a PHP by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(5) PHPs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA will confirm information before posting.

(6) PHPs have sole accountability for producing or distributing materials following OHA approval.

(7) PHPs shall comply with the Authority marketing materials submission guidelines. PHPs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with PHP marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0280 – Managed Care Prepaid Health Plan Potential Member Informational Requirements

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

(a) “Alternate Format” means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

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

(c) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO’s total OHP enrollment; or

(B) 1,000 of the MCO’s members;

(d) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-0270, Prepaid Health Plan Marketing Requirements for Potential Members.

(3) The creation of name recognition because of the MCO’s health promotion or education activities shall not constitute an attempt by the MCO to influence a client’s enrollment.

(4) An MCO or its subcontractor’s communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client’s enrollment.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) MCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) MCOs shall develop informational materials for potential members.

(8) MCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCO shall make available to potential members, upon request, information on participating providers.

(9) MCO provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(10) MCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) MCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include, but are not limited to, braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) MCOs shall ensure that all MCO staff who have contact with potential members are fully informed of MCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free certified interpreter services, and which participating providers' offices have bilingual capacity and which are accepting new members.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0300 – Managed Care Organization (MCO) Member Education and Information Requirements

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

(a) “Alternate Format” means any alternate approach to presenting print information to a person with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: Braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) “Alternate Format Statement Insert” means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state’s top sixteen preferred written languages identified by OHP enrollees. MCOs shall insert their contact information into the template;

(c) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness;

(d) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO’s total OHP enrollment; or

(B) 1, 000 of the MCO’s members;

(2) MCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the MCO or its subcontractors and providers that:

(a) Is intended solely for members; and

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

(3) MCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications shall be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health–related events. MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the MCO's health promotion or education activities shall not constitute an attempt by the MCO to influence a client's enrollment.

(5) An MCO or its subcontractor's communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(6) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) MCOs shall have a mechanism to help members understand the requirements and benefits of the MCO plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) MCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. Member education shall:

(a) Include information about the Exceptional Needs Care Coordination (ENCC) or case management services to members who are aged, blind, disabled, or have complex medical needs consistent with OAR 410-141-0405 and how to access that system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(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 and include information to members that certified health care interpreter services at provider offices are free to MCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of an MCO receiving notice of a member's enrollment, MCOs shall mail a welcome packet to new members and to members returning to the MCO twelve months or more after previous enrollment. The

packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory.

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(11) For those who are existing members, an MCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCOs shall send hard copies upon request.

(12) MCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the MCO:

(A) Welcome packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes;

(b) Include alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit;

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services.

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large (18 point) type, and braille.

(13) An MCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille;

(c) MCO'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. Explain how to choose a PCP, how to make an appointment, and the MCO'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 participating or non-participating provider services the member may self-refer;

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

(h) Explanation of Exceptional Needs Care Coordination (ENCC) services 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 ENCC services;

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

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

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

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

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

(n) Information on the MCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

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

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3260;

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

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

(q) Information about when providers may bill clients for services and what to do if they receive a bill; including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

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

(s) Information on advance directive policies including:

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

(B) The MCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;

(t) Whether or not the MCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

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

(w) Resources for help with transportation to appointments with providers;

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

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

(z) The MCO's confidentiality policy;

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

(bb) When and how members can voluntarily and involuntarily disenroll from MCOs and change MCOs;

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

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

(14) 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. MCO providers or other individuals or programs approved by the MCO may provide health education. MCOs shall

endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) MCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(c) Explanation of ENCC services and how to access ENCC services 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) MCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from MCO's participating providers. The MCO shall provide, translated as appropriate, 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 MCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that MCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) MCOs shall provide free certified health care interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care;

(b) MCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. MCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(c) MCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in

all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language;

(d) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

(16) MCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCO, members, and providers.

Stat. Auth.: ORS 413.04

Stats. Implemented: ORS 414.725

410-141-0320 – Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure Division of Medical Assistance Programs (Division) members have the rights and responsibilities included in this rule:

(a) PHPs shall communicate these policies and procedures to participating providers;

(b) PHPs shall monitor compliance with policies and procedures governing Division member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) Division members shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by participating providers the same as other people seeking health care benefits to which they are entitled;

(c) To choose a PHP or PCM as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;

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

(f) To be actively involved in the development of his/her treatment plan;

(g) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

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

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

(j) To have written materials explained in a manner that is understandable to the Division member;

(k) To receive necessary and reasonable services to diagnose the presenting condition;

(l) To receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and is medically appropriate;

(m) To obtain covered preventive services;

(n) To have access to urgent and emergency services 24 hours a day, 7 days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(o) To receive a referral to specialty practitioners for medically appropriate covered services;

(p) To have a clinical record maintained which documents conditions, services received, and referrals made;

(q) To have access to one's own clinical record, unless restricted by statute;

(r) To transfer of a copy of his/her clinical record to another provider;

(s) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act;

(t) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(u) To know how to make a complaint or appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-1410266;

(v) To request an administrative hearing with the Department of Human Services (DHS or Department);

(w) To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and

(x) To receive a notice of an appointment cancellation in a timely manner.

(3) Division members shall have the following responsibilities:

(a) To choose, or help with assignment to, a PHP or PCM as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements, and a PCP or service site;

(b) To treat the PHP's, practitioner's, and clinic's staff with respect;

(c) To be on time for appointments made with practitioners and other providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(d) To seek periodic health exams and preventive services from his/her PCP or clinic;

(e) To use his/her PCP or clinic for diagnostic and other care except in an emergency;

(f) To 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) To use urgent and emergency services appropriately and notify the PHP within 72 hours of an emergency;

(h) To give accurate information for inclusion in the clinical record;

(i) To help the practitioner, provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;

(j) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(k) To use information to make informed decisions about treatment before it is given;

(l) To help in the creation of a treatment plan with the provider;

(m) To follow prescribed agreed upon treatment plans;

(n) To tell the practitioner or provider that his/her health care is covered under the Oregon Health Plan before services are received and, if requested, to show the practitioner or other provider the Division’s Medical Care Identification form;

(o) To tell the Department worker of a change of address or phone number;

(p) To tell the Department worker if the Division member becomes pregnant and to notify the Department worker of the birth of the Division member's child;

(q) To tell the Department worker if any family members move in or out of the household;

(r) To tell the Department worker if there is any other insurance available;

(s) To pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(t) To pay the monthly OHP premium on time if so required;

(u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;

(v) To bring issues, or complaints or grievances to the attention of the PHP; and

(w) To sign an authorization for release of medical information so that the Department and the PHP can get information which is pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0340 – Oregon Health Plan Prepaid Health Plan Financial Solvency

(1) Prepaid Health Plans (PHPs) shall assume the risk for providing capitated services under their contracts/agreements with the Division of Medical Assistance Programs (Division) and/or the Addictions and Mental Health Division (AMH). PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division and/or AMH, as applicable:

(a) PHPs shall comply with solvency requirements specified in contracts/agreements with the Division and/or AMH, as applicable. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts/agreements with the Division and/or AMH. If the PHP has contracts/agreements with both the Division and AMH, separate restricted reserve fund accounts shall be maintained for each contract/agreement;

(B) Protection against catastrophic and unexpected expenses related to capitated services for PHPs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance or any other alternative determined acceptable by the Division and/or AMH, as applicable. Self-insurance must be determined appropriate by the Division and/or AMH;

(C) Maintenance of professional liability coverage of not less than $1,000,000 per person per incident and not less than $1,000,000 in the aggregate either through binder issued by an insurance carrier or by self insurance with proof of same, except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;

(D) Systems that capture, compile and evaluate information and data concerning financial operations. Such systems shall provide for the following:

(i) Determination of future budget requirements for the next three quarters;

(ii) Determination of incurred but not reported (IBNR) expenses;

(iii) Tracking additions and deletions of Division members and accounting for capitation payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of Division members; and

(vi) Documentation of and reports on the use of incentive payment mechanisms, risk-sharing and risk-pooling, if applicable.

(b) PHPs shall submit the following applicable reports as specified in agreements with the Division and/or AMH:

(A) An annual audit performed by an independent accounting firm, containing, but not limited to:

(i) A written statement of opinion by the independent accounting firm, based on the firm's audit regarding the PHP's financial statements;

(ii) A written statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities and related items;

(iii) Balance Sheet(s);

(iv) Statement of Revenue, Expenses and Net Income, and Change in Fund Balance;

(v) Statements of Cash Flows;

(vi) Notes to Financial Statements;

(vii) Any supplemental information deemed necessary by the independent accounting firm or actuary; and

(viii) Any supplemental information deemed necessary by the Division and/or AMH.

(B) PHP-specific quarterly financial reports. Such quarterly reports shall include, but are not limited to:

(i) Statement of Revenue, Expenses and Net Income;

(ii) Balance Sheet;

(iii) Statement of Cash Flows;

(iv) Incurred But Not Reported (IBNR) Expenses;

(v) Fee-for-service liabilities and medical/hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (AMH contractors); and

(viii) Corporate Relationships of contractors (FCHPs, DCOs, CDOs and PCOs) or Incentive Plan Disclosure and Detail (MHOs).

(C) PHP-specific utilization reports;

(D) PHP-specific quarterly documentation of the restricted reserve. Restricted reserve funds of FCHPs, PCOs, DCOs and CDOs shall be held by a third party. Restricted reserve fund documentation shall include the following:

(i) A copy of the certificate of deposit from the party holding the restricted reserve funds;

(ii) A statement showing the level of funds deposited in the restricted reserve fund accounts;

(iii) Documentation of the liability that would be owed to creditors in the event of PHP insolvency;

(iv) Documentation of the dollar amount of that liability which is covered by any identified risk-adjustment mechanisms.

(2) MHOs shall comply with the following additional requirements regarding restricted reserve funds:

(a) MHOs that subcapitate any work described in agreements with AMH may require subcontractors to maintain a restricted reserve fund for the subcontractor's portion of the risk assumed or may maintain a restricted reserve fund for all risk assumed under the agreement with AMH. Regardless of the alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with AMH;

(b) If the restricted reserve fund of the MHO is held in a combined account or pool with other entities, the MHO, and its subcontractors as applicable, shall provide a statement from the pool or account manager that the restricted reserve fund is available to the MHO, or its subcontractors as applicable, and has not been obligated elsewhere;

(c) If the MHO must use its restricted reserve fund to cover services under its agreement with AMH, the MHO shall provide advance notice to AMH of the amount to be withdrawn, the reason for withdrawal, when and how the restricted reserve fund will be replenished, and steps to be taken to avoid the need for future restricted reserve fund withdrawals;

(d) MHOs shall provide AMH access to restricted reserve funds if insolvency occurs;

(e) MHOs shall have written policies and procedures to ensure that, if insolvency occurs, Division members and related clinical records are transitioned to other MHOs or providers with minimal disruption.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0400 – Oregon Health Plan Prepaid Health Plan Case Management Services

(1) Prepaid Health Plans (PHPs) provide Case Management Services under the Oregon Health Plan (OHP).

(2) PHP Case Management Services are defined as follows:

(a) Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Medical Case Management as defined in OAR 410-141-0000, Definitions;

(b) Dental Care Organizations (DCOs) provide Dental Case Management as defined in OAR 410-141-0000, Definitions. DCOs shall make Dental Case Management staff available for training, Regional OHP meetings, and case conferences involving their Division of Medical Assistance Programs (Division) Members in all service areas;

(c) Mental Health Organizations (MHOs) provide Mental Health Case Management for Capitated and Non-Capitated mental health services as defined in OAR 410-141-0000, Definitions.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.725

410-141-0405 – Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination

DMAP may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

(1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all capitated services;

(2) FCHPs and PCOs shall make ENCC services available to Division members (see definition) or Division member's representative (see definition) identified as aged, blind or disabled who have complex medical needs at the request of a Division member or Division member's representative, a physician, other medical personnel serving the Division member, or the Division member's agency case manager;

(3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving Division members or Division member's representative identified as aged, blind or disabled who have complex medical needs in all their service areas;

(4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are aged, blind, disabled or who have complex medical needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;

(5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs and PCOs shall make ENCC services available to Division members identified as aged, blind or disabled who have complex medical needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to a Division member's representative during normal business hours, Monday through Friday;

(7) FCHPs and PCOs shall provide the aged, blind or disabled who have complex medical needs Division member or Division member's representative who requests ENCC services with an initial response by the next working day following the request, as appropriate;

(8) FCHPs and PCOs shall periodically inform all of their practitioners (see definition) and the practitioner's staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving

the aged, blind, disabled or who have complex medical l needs Division members or Division member's representative; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and Division members or Division member's representative;

(9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of covered services to aged, blind or disabled who have complex medical needs to Division members or Division member's representative who exhibit inappropriate, disruptive or threatening behaviors in a practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in Division member medical records as appropriate and/or in a separate Division member case file.

Stat. Auth.: ORS 409.010, 414.050, 409.110 and 414.065

Stats. Implemented: ORS 414.065

410-141-0407 – Oregon Health Plan Ombudsman Services

(1) The Department provides ombudsman services to all Division members who are aged, blind or disabled who have complex medical needs as defined in OAR 410-141-0000, Definitions.

(2) The Department shall inform all Division members who are aged, blind or disabled who have complex medical needs of the availability of ombudsman services.

Stat. Auth.: ORS 409.050

Stats. Implemented: 414.725

410-141-0410 – Oregon Health Plan Primary Care Managers

(1) Primary Care Managers (PCM) provide Primary Care Management Services under the Oregon Health Plan. PCMs provide Primary Care Management Services as defined in OAR 410-141-0000 PCM Services:

(a) Preventive services, primary care services, and specialty services including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics, and tribal health clinics;

(b) Inpatient hospital services; and

(c) Outpatient hospital services except laboratory, x-ray, and maternity management services.

(2) Services that are not PCM Case Managed Services include, but are not limited to, the following:

(a) Anesthesiology services;

(b) Dental care services;

(c) Durable medical equipment;

(d) Family Planning Services;

(e) Immunizations, treatment for communicable diseases, and treatment for sexually transmitted diseases provided by a publicly funded clinic;

(f) Laboratory services;

(g) Maternity case management services;

(h) Medical transportation services;

(i) Mental health and Substance Use Disorder treatment (SUD) services;

(j) Pharmacy services;

(k) Physical therapy, occupational therapy, speech therapy, and audiology services;

(l) Preventive services for acquired immune deficiency syndrome and human immune-deficiency virus;

(m) Routine eye examinations and dispensing of vision materials;

(n) School-based services provided under an individual education plan or an individual family service plan;

(o) Targeted case management services; and

(p) Diagnostic imaging.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

410-141-0420 – Managed Care Prepaid Health Plan Billing and Payment under the Oregon Health Plan

(1) Providers shall submit all billings for OHP members following the timeframes:

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

(A) Pregnancy;

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

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

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

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

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

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

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid 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 the Division's programs on the date of service using the Authority and PHP's tools, as applicable, and that the service to be provided is covered under the member's OHP Benefit Package. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete and have the member sign an Authority 3165, or facsimile, as described in OAR 410-120-1280.

(5) PHPs shall pay for all capitated services. These services shall be billed directly to the PHP, unless the PHP or the Authority specifies otherwise. PHPs may require providers to obtain preauthorization to deliver certain capitated services.

(6) Payment by the PHP to participating providers for capitated services is a matter between the PHP and the participating provider except as follows:

(a) PHPs shall have written procedures for processing preauthorization requests received from any provider and written procedures for processing claims submitted from any source. The procedures shall specify time frames for:

(A) Date stamping preauthorization requests and claims when received;

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

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

(D) The specific number of days following receipt of the additional information that a redetermination shall 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 410-141-0263.

(b) PHPs shall make a determination on at least 95 percent 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 shall be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the PHP shall provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHPs shall notify providers of such determination within two working days of receipt of the request;

(c) For expedited preauthorization requests in which the provider indicates or the PHP 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 PHP shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service;

(B) The PHP may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the PHP 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, PHPs shall notify providers of an approval, denial, or need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-0263. PHPs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information if the PHP justifies, to the Authority upon request, the need for additional information and how the delay is in the member's best interest. If the PHP extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 410-141-0263. The PHP shall make a determination as the member's health condition requires but no later than the expiration of the extension;

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

(f) PHPs shall provide written notification of PHP determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-0263;

(g) PHPs may not require providers to delay billing to the PHP;

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

(i) PHPs 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;

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

(7) FCHPs, PCOs, and MHOs shall pay for Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the member receives within the PHP for authorized referral care and for urgent care services or emergency services the member receives from non-participating providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(8) FCHPs and PCOs shall pay transportation, meals, and lodging costs for the member and any required attendant for out-of-state services that the FCHP and PCO have arranged and authorized when those services are available within the state, unless otherwise approved by the Authority.

(9) PHPs shall pay for covered services provided by a non-participating provider that were not preauthorized if the following conditions exist:

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

(b) The covered service was delivered in good faith without the preauthorization; and

(c) It was a covered service that would have been preauthorized with a participating provider if the PHP's referral protocols had been followed;

(d) The PHP shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.

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

(a) Sections (10) – (12) only apply to services provided by Type A or Type B hospitals to clients or members that are enrolled in a PHP;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require PHPs to continue to fully reimburse a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio.

(11) Redetermination of which Type A or Type B hospitals will transition off of CBR:

(a) No later than April 30, 2015, the Authority shall update the algorithm for calculation of the CBR methodology with the most recent data available;

(b) After recalculation for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1, 2016;

(c) The reimbursement methodology for each hospital shall be recalculated every two years thereafter;

(d) Type A and Type B hospitals located in a county that is designated as “Frontier” will not be subject to redetermination via the algorithm and shall remain on CBR.

(12) Non-contracted Type A or Type B hospital rates for those transitioning off of CBR:

(a) Charges shall be discounted for both inpatient and outpatient services. The initial reimbursement rate effective January 1, 2015 shall be based on the individual hospital’s most recently filed Medicare cost report adjusted to reflect the hospital’s Medicaid/OHP mix of services;

(b) Reimbursement rates effective for the calendar year beginning January 1, 2016 shall be based on the hospital’s most recently filed Medicare cost report adjusted to reflect the hospital’s Medicaid/OHP mix of services and further adjusted by the Actuarial Services Unit (ASU) based on the individual hospital’s annual price increases during FY 2014 – FY 2015 and the Authority’s global budget rate increase as defined by the CMS 1115 waiver, using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(c) Subsequent year reimbursement rates shall be adjusted and calculated by the Actuarial Services Unit (ASU) based on the individual hospital’s annual price increase and the Authority’s global budget rate increase as defined by the CMS 1115 waiver, using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) ASU shall contact hospitals regarding price increases during March of each year;

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

(f) A volume adjustment shall also be applied. ASU shall develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority shall determine when the volume adjustment might sunset on a hospital specific basis;

(g) Non-contracted Type A or Type B hospital reimbursement rates for those transitioning off of CBR can be found in the Rate Table section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(13) Members enrolled with PHPs may receive certain services on a FFS basis:

(a) Certain services shall be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though the services are paid by the Authority on a FFS basis. Before providing services, providers shall verify a member’s eligibility via the web portal or AVR;

(b) Services authorized by the PHP 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 contracts, billing instructions, and Authority administrative rules and supplemental information;

(e) The Authority may not pay a provider for providing services for which a PHP has received a capitation 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, AMH, or PHP except as provided for in Authority administrative rules and supplemental information (e.g., capitated services that are not included in the nursing facility all-inclusive rate); and

(g) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the FCHP or PCO would make for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of Balanced Budget Act (BBA) 4712(b)(2).

(14) Coverage of services through the OHP Benefit package of covered services is limited by OAR 410-141-0500 (Excluded Services and Limitations for OHP Clients).

(15) OHP clients enrolled with a PCM receive services on a FFS basis:

(a) PCMs are paid a per-client, per-month payment to provide PCM services in accordance with OAR 410-141-0410 (PCM Medical Management);

(b) PCMs provide primary care access and management services for preventive services, primary care services, referrals for specialty services, limited inpatient hospital services, and outpatient hospital services. The Authority payment for these PCM managed services is contingent upon PCM authorization;

(c) All PCM managed services are covered services that shall be billed directly to the Authority in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Authority administrative rules and supplemental information.

(16) All OHP members enrolled with a PCO receive inpatient hospital services on a FFS basis:

(a) May receive services directly from any enrolled provider;

(b) All services shall be billed directly to the Authority in accordance with FFS billing instructions contained in the Authority administrative rules and supplemental information;

(c) The Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Authority administrative rules and supplemental information.

(17) OHP clients not enrolled with a PHP receive services on a FFS basis:

(a) Services may be received directly from any appropriately enrolled provider;

(b) All services shall be billed directly to the Authority in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(c) The Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Authority administrative rules and supplemental information.

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.065 and 414.610 through 414.685

410-141-0440 – Prepaid Health Plan Hospital Contract Dispute Resolution

When there is a failure to reach agreement on a contract between a Fully Capitated Health Plan (FCHP) or a Physician Care Organization (PCO) and a non Type A, Type B, or Critical Access hospital, the two disagreeing parties must engage in non-binding mediation. This requirement to engage in non-binding mediation does not apply to disagreements involving emergency or urgent services as defined in Oregon Health Plan administrative rules. The hospital, FCHP, and the PCO can call for mediation. If the parties agree on a mediator their selection shall stand. If a mediator cannot be mutually agreed on, the State will make the selection from the recommended names forwarded by each party. The cost of mediation will be evenly split between the FCHP or PCO and the hospital.

(1) The mediation will proceed under the following guidelines:

(a) Access to care for Oregon Health Plan members is of critical importance;

(b) Any agreement must operate within the capitation rate received by the FCHP or PCO;

(c) Reimbursement levels must bear some relationship to the cost of the services;

(d) Consideration shall be given to the efforts of each part to manage the overall utilization of health care resources and control costs;

(e) A comparison to statewide averages of each party's cost of services, service utilization rates and administrative costs may be considered in reaching a mediation recommendation.

(2) No client medical information, communication between parties, or any other non public information used in the mediation may be disclosed to any person not a party to the mediation. All such information shall not be admissible nor disclosed in any subsequent administrative, judicial or mediation proceeding.

(3) Within thirty (30) days of the conclusion of the mediation, the mediator will issue a report to the State and to the involved parties that will include mediation findings, and recommendations. All confidential information will be excluded from the mediator's report.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.065

410-141-0480 – Oregon Health Plan Benefit Package of Covered Services

(1) Division members are eligible to receive, subject to section (11) of this rule, those treatments for the condition/treatment pairs funded on the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are medically or dentally appropriate, except that services shall also meet the prudent layperson standard defined in 410-141-0140. Refer to 410-141-0520 for funded line coverage information.

(2) Medical Assistance Benefit Packages follow practice guidelines adopted by the HERC in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.

(3) Diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services regardless of the placement of the condition on the Prioritized List of Health Services.

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

(5) Preventive services promoting health and reducing the risk of disease or illness are covered services for members. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors (See OAR 410-141-0520 Prioritized List of Health Services).

(6) Ancillary services are covered subject to the service limitations of the OHP program rules when the services are medically or dentally appropriate for the treatment of a covered condition/treatment pair, or the provision of ancillary services will enable the member to retain or attain the capability for independence or self-care.

(7) The provision of SUD services shall comply with Addictions and Mental Health Division (AMH) administrative rules, OAR 415-012-0000 "Standards for Approval/Licensure of Alcohol and Other Drug Abuse Programs," OAR 415-020 "Standards for Outpatient Synthetic Opiate Treatment Programs," OAR 415-050 "Standards for Alcohol Detoxification Centers," OAR 309-018 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services," OAR 309-019 "Outpatient Addictions and Mental Health Services," OAR 309-022 "Intensive Treatment Services for Children and Adolescents and Children's Emergency Safety Intervention Specialist," and the requirements in the SUD subsection of the Statement of Work in the CCO and PCO contracts.

(8) In addition to the coverage available under section (1) of this rule, a member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:

(a) Services may be provided if it can be shown that:

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

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

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

(D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded co-morbid conditions or disabilities shall be represented by an ICD-10-CM diagnosis code or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there shall be a medical determination and finding by the Division for fee-for-service OHP clients or a finding by the Prepaid Health Plan (PHP) for members that the terms of subsection (a)(A)–(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any member, especially a member with a disability or with a co-morbid condition, providers shall determine whether the member has a funded condition/treatment pair that would entitle the member to treatment under the program, and both the funded and unfunded conditions shall be represented by an ICD- 10-CM diagnosis code, or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity.

(9) The Division shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the OHP Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Division shall make a retrospective determination under this section, provided the Division is notified of the emergency situation during the next business day. If the Division denies a requested service, the Division shall provide

written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the HERC Prioritized List of Health Services and the Division determines the condition/treatment pair has not been identified by the HERC for inclusion on the list, the Division shall make a coverage decision in consultation with the HERC.

(11) Coverage of services available through the OHP Benefit Package of Covered Services is limited by OAR 410-141-0500 (Excluded Services and Limitations for Oregon Health Plan Clients).

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-141-0500 – Excluded Services and Limitations for Oregon Health Plan Clients and or DMAP Members

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan;

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the Oregon Health Plan administrative rules;

(c) Any treatment, service, or item for a condition that is not included on the funded lines of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the OHP client's and/or Division of Medical Assistance Programs (Division) member's OHP benefit package, are excluded;

(e) Any treatment, service, or item for a condition which is listed as a condition/treatment pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or non-covered condition/ treatment pair;

(g) Services requested by Oregon Health Plan (OHP) clients and/or Division member's in an emergency care setting which after a screening examination are determined not to meet the definition of emergency services and the provisions of 410-141-0140;

(h) Services provided to an Oregon Health Plan client and/or Division member outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) Program;

(i) Services or items, other than inpatient care, provided to an Oregon Health Plan client and/or Division member who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(j) Services received while the Division member is outside the contractor's service area that were either:

(A) Not authorized by the Division member's Primary Care Provider; or

(B) Not urgent or emergency services, subject to the Division member's appeal rights, that the Division member was outside contractor's service area because of circumstances beyond the Division member's control. Factors to be considered include but are not limited to death of a family member outside of contractor's service area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are medically appropriate to provide reasonable diagnosis and treatment or to enable the Oregon Health Plan client to attain or retain the capability for independence or self-care. Included would be those services which upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the Oregon Health Plan Prioritized List of Health Services;

(c) Services that are limited under the Oregon Medical Assistance program as identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that Oregon Health Plan clients are informed of:

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

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.065

410-141-0520 – Prioritized List of Health Services (T)

(1) The Health Evidenced Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and mental health services with "expanded definitions" of preventive services and the practice guidelines as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their website: http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx. For a hard copy, contact the Division of Medical Assistance Programs within the Oregon Health Authority (OHA).

(2) This rule, effective October 1, 2015, incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) approved January 1, 2015–December 31, 2015 Prioritized List, including October 1, 2015 interim modifications and technical changes, expanded definitions, practice guidelines, and condition treatment pairs funded through line 476.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065 & 414.727

410-141-0660 – Oregon Health Plan Primary Care Manager Provision of Health Care Services

Primary Care Managers shall ensure provision of medically appropriate covered services, including preventive services, in those categories of service included in the agreement with Division of Medical Assistance Programs (Division):

(1) Each Primary Care Manager shall provide primary care, including preventive services.

(2) Primary Care Managers shall ensure that PCM members have the same access to the Primary Care Manager PCM referral practitioners that is available to non-Division patients.

(3) Primary Care Managers shall provide primary care to the PCM members and arrange, coordinate, and monitor other PCM managed services for the PCM member on an ongoing basis.

(4) Primary Care Managers shall ensure that professional and related health services provided by the Primary Care Manager or arranged through referral by the Primary Care Manager to another provider are noted in the PCM member's clinical record.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0700 – OHP PCM Continuity of Care

(1) Primary Care Managers shall ensure the provision of PCM Managed Services for all PCM members and note in the PCM member's medical record referrals made by the Primary Care Manager to other providers for covered services:

(a) Primary Care Managers shall maintain a network of consultation and referral providers for all PCM Managed Services covered by the Primary Care Manager's agreement with Division of Medical Assistance Programs (Division). Primary Care Managers shall establish and follow procedures for referrals;

(b) Primary Care Managers shall have policies and procedures for the use of urgent care centers and emergency rooms. Primary Care Managers shall ensure that services provided in these alternative settings are documented and incorporated into the PCM member's medical record;

(c) Primary Care Managers shall have procedures for referrals that ensure adequate notice to referral providers and adequate documentation of the referral in the PCM member's medical record;

(d) Primary Care Managers shall personally take responsibility for, or designate a staff member who is responsible for, arrangement, coordination and monitoring of the Primary Care Manager's referral system;

(e) Primary Care Managers shall have procedures that ensure that relevant medical information is obtained from referral providers. These procedures shall include:

(A) Review of information by the Primary Care Manager;

(B) Entry of information into the PCM member's medical record;

(C) Arrangements for periodic reports from ongoing referral appointments; and

(f) Primary Care Managers shall have procedures to orient and train their staff/practitioners in the appropriate use of the Primary Care Manager's referral system. Procedures and education shall ensure use of appropriate settings of care;

(g) Primary Care Managers shall have procedures for processing all referrals made by telephone, whether during or after hours of operation, as a regular referral (e.g., referral form completed, information entered into PCM member's medical record, information requested from referral source);

(h) Primary Care Managers shall have procedures which ensure that an appropriate health professional will respond to calls from other providers requesting approval to provide care to PCM members who have not been referred to them by the Primary Care Manager;

(i) Primary Care Managers shall enter medical information from approved emergency visits into the PCM member's medical record;

(j) If a PCM member is hospitalized, Primary Care Managers shall ensure that:

(A) A notation is made in the PCM member's medical record of the reason, date, and expected duration of hospitalization;

(B) A notation is made in the PCM member's medical record upon discharge of the actual duration of hospitalization and follow-up plans, including appointments for practitioner visits; and

(C) Pertinent reports from the hospitalization are entered in the PCM member's medical record. Such reports shall include the reports of consulting practitioners and shall document discharge planning.

(k) Primary Care Managers shall have written policies and procedures that ensure maintenance of a record keeping system adequate to document all aspects of the referral process and to facilitate the flow of information to the PCM member's medical record.

(2) For PCM Members living in residential facilities or homes providing ongoing care, PCMs shall either provide the PCM Member's primary care or make provisions for the care to be delivered by the facility's "house doctor" for PCM Members who cannot be seen in the PCM's office.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0720 – Oregon Health Plan Primary Care Manager Medical Record Keeping

Primary Care Manager shall ensure maintenance of a medical record keeping system adequate to fully disclose and document the medical condition of the PCM member and the extent of covered services and/or PCM Case managed services received by PCM members from the Primary Care Manager or the Primary Care Manager referral provider.

(1) Primary Care Manager shall ensure maintenance of a medical record for each PCM member that documents all types of care delivered whether during or after office hours.

(2) The medical record shall include data that forms the basis of the diagnostic impression or the PCM member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The medical record shall also include:

(a) PCM member's name, date of birth, sex, address, phone number;

(b) Next of kin, sponsor, or responsible party; and

(c) Medical history, including baseline data, and preventive care risk assessment.

(3) The medical record shall include, for each PCM member encounter, as much of the following data as applicable:

(a) Date of service;

(b) Name and title of person performing the service;

(c) Pertinent findings on examination and diagnosis;

(d) Medications administered and prescribed;

(e) Referrals and results of referrals;

(f) Description of treatment;

(g) Recommendations for additional treatments or consultations;

(h) Medical goods or supplies dispensed or prescribed;

(i) Tests ordered or performed and results;

(j) Health education and medical social services provided; and

(k) Hospitalization order and discharge summaries for each hospitalization.

(4) Primary Care Managers shall have written procedures that ensure maintenance of a medical record keeping system that conforms with professional medical practice, permits internal and external medical audit, permits claim review, and facilitates an adequate system for follow-up treatment. All member medical records shall be maintained for at least four years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for record keeping within the applicable provider type, whichever time period is longer.

(5) Primary Care Managers shall have written procedures that ensure the maintenance and confidentiality of medical record information and may release such information only to the extent permitted by the Primary Care Manager's agreement with the Division of Medical Assistance Programs (Division), by federal regulation 42 CFR 431 Subpart F and by Oregon Revised Statutes. Primary Care Managers shall ensure that confidentiality of PCM members' medical records and other medical information is maintained as required by state law, including ORS 433.045(3) with respect to HIV test information.

(6) Primary Care Managers shall cooperate with Division representatives for the purposes of audits, inspection and examination of PCM member medical records.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0740 – Oregon Health Plan Primary Care Manager Quality Assurance System

(1) Primary Care Managers (PCM) shall provide services that are in accordance with accepted medical practices and with accepted professional standards:

(a) Primary Care Managers shall establish procedures and protocols for assessing quality of PCM member care:

(A) Primary Care Managers shall establish procedures for response to PCCM member complaints as outlined in OAR 410-141-0780, Primary Care Manager Complaint Procedures;

(B) Primary Care Managers shall establish or adopt criteria for adequate medical care for PCM members and shall review care received by the PCM member against these criteria. These criteria shall include those conditions and treatments identified by the Division and the Division of Additions and Mental Health (AMH) sponsored statewide quality assurance committee as in need of study, review, or improvement;

(C) Primary Care Managers may use the services of a local medical society, other professional societies, quality assurance organizations, or professional review organizations approved by the Secretary of the U.S. the Department, to assist in reviewing criteria and protocols for the adequate medical care of PCM members.

(b) Primary Care Managers are expected to maintain and improve professional competencies, when needed, in order to provide quality care to PCM members.

(2) The Division/AMH conducts continuous and periodic reviews of enrollment and disenrollment, service utilization, quality of care, PCM member satisfaction, PCM member medical outcomes for specific tracer conditions, accessibility, complaints, PCM member rights and other indicators of quality of care:

(a) The Division/AMH contracts with an external medical review organization to monitor the treatment of specific conditions against national standards for treatment of those conditions. These tracer conditions may include, but are not limited to, asthma, anemia, diabetes, hypertension, pelvic inflammatory disease, teen pregnancy, toxemia, hypertension and diabetes in pregnancy;

(b) The Division/AMH evaluates the management of adult and child preventive services through external medical review and through its research and evaluation program. These services are evaluated using national and state criteria, including criteria for mental health and chemical dependency screenings.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0760 – Oregon Health Plan Primary Care Managers Accessibility

(1) Primary Care Managers shall have written procedures which ensure that primary care, including preventive services, is accessible to PCM members.

(2) The Primary Care Managers shall not discriminate between PCM members and non-PCM member patients as it relates to benefits to which they are both entitled.

(3) Primary Care Managers shall have procedures for scheduling of PCM member appointments which are appropriate to the reasons for the visit (e.g., PCM members with non-emergency needs; PCM members with persistent symptoms; PCM member routine visits; new PCM member initial assessment).

(4) Primary Care Managers are encouraged to establish a relationship with new PCM members.

(5) Under normal circumstances, Primary Care Managers shall ensure that PCM members are not kept waiting longer than non-PCM member patients.

(6) Primary Care Managers shall have procedures for following up of failed appointments, including rescheduling of appointments, as deemed medically appropriate, and documentation in the PCM member medical record of broken appointments and recall efforts.

(7) Primary Care Managers shall have procedures to ensure the provision of triage of walk-in PCM members with urgent non-emergency medical need.

(8) When not an emergency, walk-in PCM members should either be scheduled for an appointment as medically appropriate or be seen within two hours.

(9) Primary Care Managers shall have procedures that ensure the maintenance of telephone coverage (not a recording) at all times either on-site or through call sharing or an answering service, unless the Division of Medical Assistance Programs (Division) waives this requirement in writing because of the Primary Care Manager's submission of an alternative plan that will provide equal or improved telephone access.

(10) Primary Care Managers shall ensure that the persons responding to telephone calls enter relevant information into the PCM member's medical record.

(11) Primary Care Managers shall ensure a response to each telephone call within a reasonable length of time. The length of time shall be appropriate to the PCM member's stated condition.

(12) Primary Care Managers shall have procedures that ensure that all persons answering the telephone have sufficient communication skills to reassure PCM members and encourage them to wait for a return call in appropriate situations.

(13) Primary Care Managers are expected to have a plan to access qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking PCM members. The plan shall address the provision of interpreter services by phone and in person. Such interpreters must be capable of communicating in English and the primary language of the PCM members and be able to translate medical information effectively. A substantial population is 35 non-English speaking households, enrolled with the Primary Care Manager, which have the same language. A non-English speaking household is a household that does not have an adult PCM member who is capable of communicating in English.

(14) Primary Care Managers shall provide education on the use of services, including Urgent Care Services and Emergency Services. The Division may provide Primary Care Managers with appropriate written information on the use of services in the primary language of each substantial population of non-English speaking PCM members enrolled with the Primary Care Manager.

(15) Primary Care Managers shall ensure that when a Medical Practitioner does not respond to a telephone call, there are written protocols specifying when a practitioner must be consulted and if medically appropriate, all such calls shall be forwarded to the on-call medical practitioner.

(16) Primary Care Managers shall have adequate practitioner backup as an operative element of the Primary Care Manager's after-hours care. Should the Primary Care Manager be unable to act as PCM for the PCM member, the Primary Care Manager shall designate a substitute Primary Care Manager.

(17) Primary Care Managers shall ensure compliance with requirements of the Americans with Disabilities Act of 1990.

(18) Primary Care Managers shall ensure that services, facilities and personnel are prepared to meet the special needs of visually and hearing impaired PCM members.

(19) Primary Care Managers shall arrange for services to be provided by referral providers when the Primary Care Manager does not have the capability to serve specific disabled populations.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0780 – Oregon Health Plan Primary Care Manager Complaint Procedures

(1) PCMs shall have procedures for accepting, processing and responding to all complaints from PCM members or their representatives:

(a) PCMs shall have procedures for resolving all complaints. PCMs shall afford PCM members the full use of the procedures, and shall cooperate if the PCM member decides to pursue a remedy through the Division of Medical Assistance Programs (Division) hearing process. Complaints are defined in OAR 410-141-0000, Definitions;

(b) PCMs shall designate PCM staff member or staff members who shall be responsible for receiving, processing, directing, and responding to complaints;

(c) PCMs shall ensure that all information concerning a PCM member's complaint is kept confidential except that the Division has a right to this information without a signed authorization for release of medical information from the PCM member. If a PCM member makes a complaint or files a hearing request, the PCM may ask the PCM member to sign an authorization for release of medical information to those persons and to the extent necessary to resolve the complaint or hearing request. The PCM shall inform the PCM member that failure to sign an authorization for release of medical information may make it impossible to resolve the complaint or hearing request;

(d) PCMs shall have procedures for informing PCM members orally and in writing about complaint procedures, which shall include the following:

(A) Written material describing the complaint process; and

(B) Assurance in all written and posted material of PCM member confidentiality in the complaint process;

(C) Upon request, Division of Medical Assistance Programs shall provide PCMs with standard materials for tracking and documenting PCM member complaints.

(e) PCMs shall have procedures for the receipt, disposition and documentation of all Complaints from PCM members PCMs shall make available copies of the complaint forms (DMAP 3001). PCM members may register a complaint in the following manner. complaints: A PCM member may relate any incident or concern to the PCM or other staff person by stating this is a complaint:

(A) If the PCM member indicates dissatisfaction, the PCM or staff person shall advise the PCM member that he or she may make a complaint;

(B) A staff person shall direct the PCM member to the PCMs staff person designated for receiving complaints;

(C) A PCM member may choose to utilize the PCM's internal complaint procedure in addition to or in lieu of a Division hearing. If a PCM member makes a complaint to the PCM staff person designated for receiving complaints, the staff person shall notify the PCM member that the PCM member has the right to enter a written complaint with the PCM or may attempt to resolve the complaint orally;

(D) Complaints concerning denial of service or service coverage shall be handled as described in subsection (1)(h) of this section in addition to procedures for oral or written complaints;

(E) All Complaints made to the PCM staff person designated to receive complaints shall be entered into a log. The log shall identify the PCM member, the date of the complaint, the nature of the complaint, the resolution and the date of resolution;

(F) If the PCM denies a service or service coverage, the PCM shall notify the PCM member of the right to a hearing.

(f) Oral complaints:

(A) If the PCM member chooses to pursue the complaint orally through the PCM's internal complaint procedure, the PCM shall within five working days from the date the oral complaint was received by the PCM either:

(i) Make a decision on the complaint; or

(ii) Notify the PCM member in writing that a delay in the PCM's decision of up to 30 calendar days from the date the oral complaint was received by the PCM is necessary to resolve the complaint. The PCM shall specify the reasons the additional time is necessary.

(B) The PCM's decision shall be communicated to the PCM member orally or in writing no later than 30 calendar days from the date of receipt of the complaint. A written decision shall have both the Notice of Hearing Rights (DMAP 3030) and the complaint form (DMAP 3001) attached. An oral communication shall include informing the PCM member of their right to a hearing;

(C) If the PCM member indicates dissatisfaction with the decision, the PCM shall notify the PCM member that the PCM member may pursue the complaint further with a Division hearing.

(g) Written complaints: If the PCM member files a written complaint with the PCM, which does not concern denial of service or service coverage, the following procedures apply:

(A) The complaint shall be reviewed, investigated, considered or heard by the PCM;

(B) A written decision shall be made on a PCM member's written complaint. The decision shall be sent to the PCM member no later than 30 calendar days from the date of receipt of the written complaint, unless further time is needed for the receipt of information requested from or submitted by the PCM member. If the PCM member fails to provide the requested information within 30 calendar days of the request by the PCM, or another mutually agreed upon time-frame, the complaint may be resolved against the PCM member. The decision on the complaint shall review each element of the PCM member 's complaint and address each of those concerns specifically;

(C) The PCM's decision shall have the Notice of Hearing Rights (DMAP 3030) attached.

(h) Complaints concerning denial of service or service coverage: If a complaint made to the PCM staff person designated to receive complaints concerns a denial of service or a service coverage decision, the following procedures apply in addition to the regular complaint procedures. The PCM staff person shall notify the PCM member in writing of the decision which denied the service or coverage within five working days. The decision letter shall include at least the following elements:

(A) The service requested;

(B) A statement of service denial;

(C) The basis for the denial;

(D) A statement that the PCM member has a right to request a Division hearing, and that in order to request such a hearing the PCM member must submit a Fair Hearing Request form (CAF 443) to the PCM member's Department office within 45 calendar days of the date of the PCM's decision on an oral or written complaint concerning denial of service or service coverage;

(E) A statement that a Division hearing request may be made in addition to or instead of using the PCM's complaint procedure;

(F) A copy of the Notice of Hearing Rights (DMAP 3030) and Fair Hearing Request (CAF 443) shall be attached.

(i) PCM member use of PCM complaint procedure with request for hearing:

(A) If the PCM member chooses to use the PCM's complaint procedure as well as the Division hearing process, the PCM shall ensure that either the complaint procedure is completed prior to the date on which the Division hearing is

scheduled or obtain the written consent of the PCM member to postpone the Division hearing. If the PCM member consents to a postponement of the Division hearing, the PCM shall immediately send such written consent to the Division and to the local Department office;

(B) The PCM staff person shall encourage the PCM member to use the PCM's complaint procedure first, but shall not discourage the PCM member from requesting a Division hearing;

(C) If the PCM member files a request for a Division hearing, the Division shall immediately notify the PCM. The Division hearing process cannot be delayed without the PCM member's consent;

(D) The PCM staff person shall begin the process of establishing the facts concerning the complaint upon receipt of the complaint regardless of whether the PCM member seeks a Division hearing or elects the complaint process, or both;

(E) If a Division hearing is requested by a PCM member, PCM shall cooperate in the hearing process and shall make available, as determined necessary by the hearings officer, all persons with relevant information and all pertinent files and medical records.

(j) Should a PCM member feel that his or her medical problem cannot wait for the normal PCM review process, including the PCM's final resolution, at the PCM member's request, the PCM shall submit documentation to the Division’s Medical Director within, as nearly as possible, two working days for decision as to the necessity of an expedited Division hearing. The Division’s Medical Director shall decide within, as nearly as possible, two working days if that PCM member is entitled to an expedited Division hearing.

(2) The PCM's documentation shall include the log of complaints, a file of written complaints and records or their review or investigation and resolution. Files of complaints shall be maintained for a minimum of two calendar years from date of resolution.

(3) PCMs shall review and analyze all complaints.

(4) PCMs shall comply with and fully implement the Division hearing decision. Neither implementation of a Division hearing decision nor a PCM member's request for a hearing may be a basis for a request by the PCM for disenrollment of a PCM member.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0800 – Oregon Health Plan Primary Care Manager Informational Requirements

(1) The Division of Medical Assistance Programs (Division) shall provide basic models of informational materials which PCMs may adapt for PCM members' use.

(2) PCMs shall ensure that all of their staff who have contact with potential PCM members are fully informed of the PCM and Division policies, including enrollment, disenrollment and complaint policies.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0820 – Oregon Health Plan Primary Care Manager Member Education

PCMs shall have an ongoing process of PCM member education and information sharing which includes orientation to the PCM, health education and appropriate use of emergency facilities and urgent care:

(1) The Division of Medical Assistance Programs (Division) shall provide basic information about the use of PCM services in a PCM Member Handbook;

(2) PCMs shall provide new PCM members with written information sufficient for the PCM member to use the PCM's services appropriately. Written information shall contain, at a minimum, the following elements:

(a) Location and office hours of the PCM;

(b) Telephone number to call for more information;

(c) Use of the appointment system;

(d) Use of the referral system;

(e) How to access urgent care services and advice;

(f) Use of emergency services; and

(g) Information on the complaint process.

(3) PCMs shall have procedures and criteria for health education designed to prepare PCM members for their participation in and reaction to specific medical procedures, and to instruct PCM members in self-management of medical problems and in disease and accident prevention. Health education may be provided by the PCM, by any health Practitioner or by any other individual or program approved by the PCM. The PCM shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures;

(4) PCMs shall develop an educational plan for PCM members for health promotion, disease and accident prevention, and patient self-care. The Division may assist in developing materials that address specifically identified health education problems to the population in need.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.725

410-141-0840 – Oregon Health Plan Primary Care Manager Member Rights And Responsibilities

(1) Primary Care Managers (PCM) shall ensure that PCM members are treated with the same privacy, dignity and respect as other patients who receive services from the Primary Care Managers.

(2) PCM members have both rights and responsibilities as follows:

(a) PCM members have the right to appropriate access to the Primary Care Manager. PCM members have the responsibility to keep appointments made with the Primary Care Manager;

(b) PCM members have the right to preventive services. PCM members have the responsibility to seek periodic health exams for children and adults based on medically appropriate guidelines for age, sex and risk factors;

(c) PCM members have the right to services necessary and reasonable to diagnose the presenting condition of the PCM member. PCM members have the responsibility to seek out diagnostic services from the Primary Care Manager except in an emergency.

(d) PCM members have the right to appropriate urgent care services; and emergency services. PCM members have the responsibility to use the Primary Care Manager whenever possible. PCM members have the responsibility to use urgent care services before emergency services whenever possible:

(A) PCM members have the right to written information on how to access emergency care and urgent care. PCM members have the responsibility to use emergency care appropriately. PCM members have the right to make a complaint if they believe that a request for payment for emergency services has been erroneously denied by the Primary Care Manager. PCM members may request a hearing before a Division of Medical Assistance Programs (Division) representative if their complaint is not acted on, to their satisfaction, by the Primary Care Manager;

(B) In addition to access to emergency care, PCM members have the right to the following rriage services:

(i) A service which allows PCM members to access Primary Care Managed Services and contact the Primary Care Manager on a 24-hour, 7-day-aweek basis, when the PCM member requires urgent or emergency care;

(ii) To have the referral emergency room notified about the PCM member's presenting problem, and whether or not the Primary Care Manager will meet the PCM member there;

(iii) To have a health professional available to Triage urgent care and emergencies for PCM members during regular working hours. This service includes individuals who walk in for service or who telephone for assessment.

(e) PCM members have the right to access specialty practitioners with the Primary Care Manager's referral when their condition warrants a referral. PCM members have the responsibility to access specialty services through referral by the Primary Care Manager;

(f) PCM members have the right to maintenance of a medical record which documents the medical condition of the PCM member and the services received by the PCM member. The PCM member has the right of access to his or her own medical record and to request transfer of a copy of his or her own record to another provider when appropriate. PCM members have the responsibility to give accurate information for inclusion into the record and to request transfer of a copy of the record to a new provider when changing providers;

(g) PCM members have the right to medically appropriate covered services which meet generally accepted standards of practice. PCM members have the right to information about medical services which permits them to make an informed decision about proposed medical services. PCM members have the right to refuse any recommended services. PCM members have the responsibility to use the information to make informed decisions about services. PCM members have the responsibility to follow prescribed treatment plans, once the PCM member has agreed to the plan;

(h) PCM members have the right to execute a statement of their wishes for treatment, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care. This right is established and must be adhered to in accordance with ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act.

(3) PCM members have the right to medically appropriate services covered under the Oregon Health Plan. PCM members have the responsibility to inform medical providers of their coverage as PCM members prior to receiving services

(4) PCM members enrolled with Primary Care Managers or their representatives have the right to make complaints to Primary Care Managers and to request hearings through the Division hearings process. PCM members have the responsibility to attempt resolution of complaints with the Primary Care Manager and to sign a authorization for release of pertinent files and medical records.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.065

410-141-0860 – Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment

(1) Definitions:

(a) ACA-qualified conditions will be posted on the agency website. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease, BMI over 25 or for patients under the age of 20 (the equivalent measure would be BMI equal or greater than 85 percentile), HIV/AIDS, hepatitis, chronic kidney disease and cancer;

(b) An ACA-qualified patient is a patient who meets the criteria described in these rules as authorized by Section 2703 of the Patient Protection and Affordable Care Act.

(c) ACA-qualified patients are individuals with:

(A) A serious mental health condition; or

(B) At least two chronic conditions proposed by the state and approved by CMS; or

(C) One chronic condition and at risk of another qualifying condition as described above;

(i) Providers and plans are to use information published by the US Preventive Services Task Force, Bright Futures, and HRSA Women's Preventive Services when making decisions about the particular risk factors for an additional chronic condition that may lead a patient with one chronic condition to meet the criteria of one chronic condition and at risk of another.

(ii) The conditions and risk factors shall be documented in the patient's medical record.

(d) Core services are defined as:

(A) Comprehensive Care Management is identifying patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities may include but are not limited to population panel management, defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end- of-life care plans when appropriate.

(B) Care coordination is an integral part of the PCPCH. Care coordination functions will include the use of the person centered plan to manage such

referrals and monitor follow up as necessary. The Division shall assign clients to a provider, clinic, or team to increase continuity of care and ensure responsibility for individual client care coordination functions, including but not limited to:

(i) Tracking ordered tests and notifying all appropriate care-givers and clients of results;

(ii) Tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to clients and clinicians; and

(iii) Directly collaborating or co-managing clients with specialty mental health and substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long- term care services and supports. (The Division strongly encourages co-location of behavioral health and primary care services.);

(C) Health promotion is demonstrated when a PCPCH provider supports continuity of care and good health through the development of a treatment relationship with the client, other primary care team members and community providers. The PCPCH provider shall promote the use of evidence-based, culturally sensitive wellness and prevention by linking the client with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. The PCPCH shall use health promotion activities to promote patient and family education and self-management of their ACA-qualifying conditions;

(D) Comprehensive transitional care is demonstrated when a PCPCH emphasizes transitional care with either a written agreement or procedures in place with its usual hospital providers, local practitioners, health facilities and community-based services to ensure notification and coordinated, safe transitions, as well as improve the percentage of patients seen or contacted within one (1) week of facility discharges;

(E) Individual and family support services are demonstrated when a PCPCH has processes in place for:

(i) Patient and family education;

(ii) Health promotion and prevention;

(iii) Self-management supports; and

(iv) Information and assistance to obtain available non-health care community resources, services and supports.

(F) Referral to community and social support services is demonstrated through the PCPCH's processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

(e) Patient Centered Primary Care Home (PCPCH) pursuant to OAR 409-055-0010(7) is defined as a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to 409-055-0040;

(f) A PCPCH "team" is interdisciplinary and inter-professional and must include non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, community health workers, personal health navigators and peer wellness specialists authorized through State plan or waiver authorities. (Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized). These PCPCH professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities;

(g) Person-centered plan is defined as the plan that shall be developed by the PCPCH and reflect the client and family/caregiver preferences for education, recovery and self-management as well as management of care coordination functions. Peer supports, support groups and self-care programs shall be utilized to increase the client and caregivers knowledge about the client's health and health-care needs. The person-centered plan shall be based on the needs and desires of the client including at least the following elements:

(A) Options for accessing care:

(B) Information on care planning and care coordination;

(C) Names of other primary care team members when applicable; and

(D) Information on ways the team member participates in this care coordination;

(g) Primary Care Managers (PCM) must be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

(A) Doctors of medicine;

(B) Doctors of osteopathy;

(C) Naturopathic physicians;

(D) Nurse Practitioners;

(E) Physician assistants.

(F) Naturopaths who have a written agreement with a physician sufficient to support the provision of primary care, including prescription drugs, and the necessary referrals for hospital care.

(2) Enrollment requirements:

(a) To enroll as a PCM, all applicants must:

(A) Be enrolled as Oregon Division of Medical Assistance Programs (Division) providers;

(B) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(C) Complete and sign the PCM Application (DMAP 3030 (7/11).

(D) If the Division determines that the PCM or an applicant for enrollment as a PCM does not comply with the OHP administrative rules pertaining to the PCM program or the Division's General Rules, or if the Division determines that the health or welfare of Division clients may be adversely affected or in jeopardy by the PCM, the Division may:

(i) Deny the application for enrollment as a PCM;

(ii) Close enrollment with an existing PCM; or

(iii) Transfer the care of those PCM clients enrolled with that PCM until such time as the Division determines that the PCM is in compliance.

(E) The Division may terminate their agreement without prejudice to any obligations or liabilities of either party already accrued prior to termination, except when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members. The PCM shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members.

(b) To enroll as a PCPCH with the Division, all applicants must:

(A) Apply to and be “recognized” as a PCPCH by the Oregon Health Authority (Authority) as organized in accordance with relevant Oregon Office of Health Policy and Research (OHPR) administrative rules (OAR 409-055-0000 to 409-055-0090), the Division administrative rules (chapter 410, division 141), and OHPRs Oregon Patient Centered Primary Care Home Model, dated October 2011 and found at www.primarycarehome.oregon.gov. The Authority grants PCPCH recognition only when a practice, site, clinic, or individual provider is successful in the application process with the Authority;

(i) The type of practice, site, clinic or individual provider that may apply to become a PCPCH, include physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine), Certified Nurse Practitioner and Physician Assistants, clinical practices or clinical group practices; FQHCs; RHCs; Tribal clinics; Community health centers; Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers.

(ii) PCPCH services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

(B) PCPCH providers must complete the enrollment process in order to receive reimbursement (OAR 410-120-1260), except as otherwise stated in OAR 410-120-1295. The Provider Enrollment Attachment (attachment to the Provider Enrollment Agreement) sets forth the relationship between the Division and the PCPCH site (recognized clinic or provider) to receive payment for providing PCPCH services under OHP OAR 410-141-0860.

(C) New PCPCH enrollment shall be effective on or after October 1, 2011 or the date established by the Division upon receipt of required information. (Note: PCPCH tier enrollment changes shall be effective the first of the next month or a date approved by the Division).

(D) The PCPCH enrollment process requires the PCPCH submit a list of fee-for-service (FFS) clients to the Division in a format approved by the Division. The PCPCH must identify current OHP clients being treated within their practice. The PCPCH shall identify that patients are ACA qualified or not as defined in these rules.

(E) PCPCHs serving clients enrolled in a managed care organization (MCO, FCHP or PCO) must consult the MCO on the procedures for developing an OHP client list. The MCO shall submit the list of their identified clients to the Division. Identified client lists are submitted to the Division so that the Division can assign the appropriate clients to the PCPCH and begin making payments for services rendered, all in accordance with relevant OARs.

(F) Termination of PCPCH enrollment shall be the date established by the Authority. All providers shall comply with Provider Sanctions as outlined in OAR 410-120-1400.

(3) The Division shall make per member per month (PMPM) payments based on the PCPCH clinic's recognized tier and on the patient's ACA status.

(a) PCPCH payments are made as follows:

(A) For fee-for-service (FFS) ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(i) $ 10 for tier 1;

(ii) $15 for tier 2 and;

(iii) $24 for tier 3.

(B) For FFS non-ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(i) $2 for tier 1;

(ii) $4 for tier 2 and;

(iii) $6 for tier 3.

(b) For MCO enrolled ACA-qualified members MCO's are responsible for payment to PCPCH providers assigned to the PCPCH. MCOs shall make payments to PCPCH clinics in accordance with OAR 409-055-0030. If an MCO retains any portion of the PCPCH payment, that portion shall be used to carry out functions related to PCPCH and is subject to approval and oversight by the Division.

(c) MCOs that wish to use PCPCH payment methodology or amount different than Division must receive Division approval

(d) The Division shall not provide additional PMPM payment to the MCOs for non-ACA-qualified members. For MCO enrolled non-ACA-qualified members PCPCH payment responsibility will be integrated into MCOs capitation payments and covered services at the next opportunity to revise capitation rates expected on or near July 1, 2012.

(e) MCOs must use an alternative payment methodology that supports the Division's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of FFS reimbursement models. PMPM payment is an alternative methodology.

(f) It is the Division's intention that the PCPCH Program will not duplicate other similar services or programs such as PCM and medical case management, and the Authority shall not make PCPCH payments for patients who participate in these programs. The Division may review on a program to program basis if care coordination programs are complimentary with PCPCH.

(4) Client Assignment:

(a) OHP clients' participation with PCPCH is voluntary. OHP clients can opt-out at any time from a PCPCH.

(b) The Division will provide client notice of PCPCH assignment including information about benefits of PCPCH and how to notify the Division if they wish to opt out.

(c) The Division shall remove PCPCH assignment from clients who choose not to participate in a PCPCH Program.

(d) Upon completion of PCPCH enrollment process and approval from CMS, the Division will implement PMPM payments for non-ACA patients who are not enrolled in an FCHP or PCO. The Division shall integrate this service into rate setting and managed care responsibilities at the first available opportunity. This provision only affects the startup phase of the program and is acknowledgment of a more gradual implementation than was originally intended;

(e) Clients assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus (BMH, BMP, BMM or BMD) benefit plans. This excludes CAWEM Plus (CWX) and QMB (MED) only.

(5) Documentation Requirements:

(a) The PCPCH must coordinate the care of all assigned clients who do not choose to opt out of the PCPCH Program, to ensure they have a "person-centered plan" that has been developed with the client or the client's caregiver. The PCPCH must provide an assigned client with at least one of the six "core" services as defined in Oregon State Medicaid Plan, each quarter and document the service(s) in the medical record in order to be eligible for payment;

(b) PCPCHs shall assure that the patient's engagement, education and agreement to participate in the PCPCH program are documented within six months of initial participation;

(c) PCPCHs shall assure that for each patient, providers are working with the patient to develop a person-centered plan within six months of initial participation and revise as needed;

(d) For ACA-qualified patients, PCPCH clinics shall provide one of the six core services or an activity that is defined in the service definition at least quarterly. Documentation of the services provided must be kept in the patient's medical record;

(e) PCPCHs shall assure that they notify the Division when a patient moves out of the service area, terminates care, or no longer receives primary care from the PCPCH clinic as stated in OAR 410-141-0080 and 410-141-0120. Patient assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another PCPCH provider begins primary care before the end of the month. In this situation, the disenrollment and payment will be prorated;

(f) PCPCH clinics and MCOs must report to the Division a complete list of their Medicaid PCPCH patients, no less than quarterly. The Division will not make payments for patients that are not reported on these quarterly reports or for patients where documentation requirements are not met; PCPCH clinics and MCOs may provide the Division information on new member assignment or termination member assignment on a more frequent basis if they desire;

(g) PCPCH clinics must log on to the PCPCH provider portal, which will be available at www.primarycarehome.oregon.gov, no less than quarterly. In conjunction with submission of the quarterly patient list, logging on to the PCPCH provider portal serves as evidence that the clinic has complied with the service and documentation requirements. Clinics will have the opportunity to track quality measures through the portal and use this as a panel management tool;

(h) PCPCH clinics that have their own information technology system can use their own system as an alternative to the PCPCH provider portal. To do this, PCPCH clinics must:

(A) Be able to document quarterly usage of the system for panel management purposes; and

(B) Submit a request in writing to the Division to utilize their system as an alternative. The Division will respond to each request in writing.

(i) MCOs, no later than the 15th of January, April, July and October shall provide the Division with the following information for the preceding quarter:

(A) Number of clinics or sites that meet PCPCH standards;

(B) Number of Primary Care Providers in those service delivery sites;

(C) Number of patients receiving primary care in those sites; and

(D) Number of ACA-qualified patients receiving primary care at those sites

(j) PCPCH shall provide their Division PCPCH clinic number when referring a patient to another provider to ensure it is added to the claim as a referring provider. The PCPCH will also need to document the referral in the patient's medical record.

Stat. Auth.: ORS 413.042, 414.065;

Stats. Implemented: ORS 414.065

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 division120 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

410-141-3040 – Service Area Change (SAC) for Existing Coordinated Care Organizations (CCOs) (T)

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

(a) “Applicant” means a certified coordinated care organization (CCO) that submits an application seeking recertification and a contract amendment for a SAC. The CCO is described, for this use, as the applicant, upon its submission of the CCO Letter of Intent to Apply;

(b) “Capacity” means the sum of enrollment limits for CCOs in a service area;

(c) “Certified” means the Authority's determination that an entity meets the criteria in OAR 410-141-3015 for being a CCO through initial certification;

(d) “Document Review” means the review conducted by the Authority, occurring after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant’s ability to serve Medicaid beneficiaries in the requested service areas. Successful meeting of the requirements of the document review entitles the applicant to receive a contract amendment for the SAC and to be recertified as a CCO in the delivery of Medicaid services;

(e) “Enrollment Limit” means a CCO’s maximum enrollment by service area, as specified in the Authority’s contract with the CCO;

(f) “Letter of intent to apply (LOIA)” means a letter from a CCO to the Authority stating the CCO’s intent to submit a SAC packet in response to a service area need. A LOIA may be binding or non-binding, as specified in the Authority’s announcement of the service area need;

(g) “Recertification” means the process outlined in this rule, allowing the CCO contractor to submit an abbreviated application to apply as an existing CCO for a new CCO service area;

(h) “Service Area Change (SAC)” means a change in a CCO’s service area or enrollment limits, as specified in the Authority’s contract with the CCO;

(i) “Service area need” means when the Authority identifies a need, as defined in section (3), for existing CCOs to apply to the Authority for a SAC to serve a service area;

(j) “SAC packet” means the packet of application documents that the Authority provides to CCOs applying for a SAC.

(2) A CCO shall make every effort to provide the Authority with a Letter of Intent to Exit the Service Area not less than150 calendar days prior to the CCO’s proposed

withdrawal from all or a portion of its service area. The Authority shall work with each CCO for a workable exit transition.

(3) The Authority may determine whether a service area need exists under the following circumstances:

(a) If a CCO withdraws from all or a portion of its service area; or

(b) If the Authority identifies an actual or prospective deficiency in capacity that may negatively impact enrollees' health or safety.

(4) After identifying a service area need, the Authority shall announce, in letters to the existing CCOs, its intent to accept LOIAs from CCOs for SACs in stated service areas. The announcement shall specify the date on which LOIA is due.

(5) By the due date specified in the Authority's announcement of service area need, interested CCOs shall submit their LOIA. In the LOIA, the CCO shall designate a sole point of contact for this process.

(6) CCOs shall be sent a SAC packet for their completion. It consists of SAC guidance documents. Interested CCOs shall complete the Authority's SAC process for application, review, and recertification on the schedule prescribed by the Authority.

(7) By the due date set forth in the Authority's announcement of service area need, the applicant's SAC packet shall be completed in its entirety and returned to the Authority's contract administration unit. The recertification application is the applicant's offer to enter into a contract amendment for the period specified in the SAC packet.

(8) The Authority shall review packets from all CCOs who apply, considering only packets that are responsive, completed as described in the SAC guidance document, and submitted in the time and manner described in this rule.

(9) After the final submission of the SAC packet and all additional requested information received by the Authority, the Authority shall complete the document review of submitted packets. The applicants are eligible for recertification based on criteria specified in the SAC guidance document, the application, written assurances, and any additional information that the Authority obtains and deems satisfactory. The applicant shall be responsible for and meet standards established by the Authority and the current CCO contract.

(10) If two or more CCOs meet the requirements to expand into a service area, then the Authority shall allow all the qualified CCOs to serve that service area. The Authority shall certify all CCOs who apply for the service area change and meet the specified standards as supported in OAR 410-141-3010.

(11) Applicants who wish to dispute any Authority actions or decisions pertaining to the SAC process may engage in dispute resolution as provided for in OAR 410-141-3267.

Stat. Auth: ORS 413.042, ORS 414.645, ORS 414.625

Stats. Implemented: ORS 413.042

410-141-3050 – CCO Enrollment for 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 division141 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 (T)

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

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

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

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

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

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

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

(2) The following populations may not be enrolled into a CCO for any type of health care coverage including:

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

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

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

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

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

basis only until the hospital discharges the client. The individual will receive dental services through the DCO;

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

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

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

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

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care;

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

(A) A client has the option to enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(B) A client enrolled in Medicare Advantage, whether or not they pay their own premium, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;

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

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

(6) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;

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

(A) Be pregnant;

(B) State that her intention is to have a home birth;

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

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

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

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

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

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

(II) Abnormal Bleeding;

(III) Low–lying placenta within 2 cm. or less of cervical os;

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

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

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

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

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

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

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

(B) The Authority finds no reasonable alternatives.

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

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

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

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

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

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

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

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

(10) If a service area changes from mandatory enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-141-3080.

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

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

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

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

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

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

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(13) Coordinated care services shall begin as of the effective date of enrollment with the CCO except for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;

(b) For persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

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

(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

410-141-3065 – Coordinated Care Organization (CCO) Enrollment Requirements for Individuals Receiving Residential Substance Abuse Disorder (SUD) Treatment Services

This rule implements and further describes how the Oregon Health Authority (Authority) will administer its authority under 410-141-3060 for purposes of making enrollment decisions and 410-141-3080 for purposes of making disenrollment decisions for adult and adolescent individuals receiving residential SUD treatment services;

(1) The Authority has determined that, to the maximum extent possible, all individuals should be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. Unless disenrollment is authorized by the Authority in accordance with this section, OAR 410-141-3050 or 410-141-3080: If the Authority determines that disenrollment should occur, the CCO will continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible managed care organization when applicable.

(2) It is not unusual for individuals to receive residential SUD treatment services outside of their residential/home county and outside of the coordinated care organization's delivery service area. Receiving residential SUD treatment is considered a temporary absence from the individual's residential/home-county and does not represent a change of residence or a change in enrollment when the individual is reasonably likely to return to the coordinated care organization's delivery service area at the end of the residential treatment stay.

(3) If the individual is enrolled in a coordinated care organization on the same day the individual is admitted to the residential treatment services, the CCO shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO's service area: The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled. An admission to a residential SUD facility is deemed a temporary placement and does not constitute a change of residence for the purposes of CCO enrollment and does not constitute a basis for disenrollment from the CCO, notwithstanding OAR 410-141-3080. If the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority will re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO. If the individual was enrolled in a different CCO in error, the Authority will disenroll the individual from that CCO and recoup the capitation payments.

(4) If the individual is enrolled in a CCO after the first day of an admission to a residential SUDs treatment service facility, the individual will be retro disenrolled from the CCO, and any capitation payment will be recouped. The date of enrollment shall be effective the next available enrollment date following discharge from the residential SUD treatment service facility.

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

Stats. Implemented: ORS 414.610-685

410-141-3066 – CCO Enrollment Requirements for Temporary Out-of-Area Behavioral Health Treatment Services

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

(a) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders;

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

(c) “Temporary Placement” means hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.

(2) The Authority has determined that, to the maximum extent possible, all individuals shall be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. This rule implements and further describes how the Authority administers its authority under OAR 410-141-3060 and OAR 410-141-3080 for purposes of making enrollment decisions for adult and young adult individuals, 14 through and including 17 years of age, receiving temporary out-of-area behavioral health treatment services:

(a) For program placements in Child Welfare, Behavioral Rehabilitative Services, Oregon Youth Authority, and Psychiatric Residential Treatment Services, see OAR 410-141-3050 for program specific rules;

(b) For program placements in Secure Children’s In-Patient (SCIP) and Secure Adolescent In-Patient (SAIP), CCOs shall work with the Authority in managing admissions and discharges;

(c) The member shall remain enrolled with the CCO for delivery of SCIP and SAIP services. The CCO shall bear care coordination responsibility for the entire length of stay, including admission, determination, and planning.

(3) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO on the same day the individual is admitted to the residential treatment services, the CCO shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO’s service area. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(4) CCO assignment is based on the member’s residence and referred to as Home CCO. Home CCO enrollment for temporary out-of-area placement shall:

(a) Meet Oregon residency requirements defined in OAR 410-200-0200;

(b) Be eligible for enrollment into a CCO as specified in OAR 410-141-3060;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to hospital, institutional, and residential placement. If the client has no enrollment history, new enrollment shall reflect most recent permanent residence prior to hospital, institutional, and residential placement; and

(d) Be consistent with OAR 410-141-3080 when the client exercises recipient choice, where the client is able to actively participate in their own recovery and direct their own care. If the client is unable to designate county of residence, as indicated in OAR 410-200-0200, the Authority shall designate the Home CCO as the geographic location of the client at the most recent residency and CCO enrollment prior to hospitalization.

(5) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:

(a) Upon State Hospital discharge, the Authority and the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement;

(b) If the client has no residency or enrollment history or no recent pre-hospitalization enrollment history, but the client's permanent residency is indicated other than temporary placement location, the Authority shall enroll pursuant to section (3) (c) of this rule Home CCO enrollment;

(c) If the client has no residency or enrollment history prior to hospitalization, the Authority shall enroll in placement service area.

(6) For new and existing temporary residential placements, CCOs shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, dental, and transportation when within the scope of the CCO's contract, including when member's temporary placements are outside the CCO service area. CCO's shall coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, CCO's shall coordinate all care for accompanying dependent members.

(7) Enrollment shall follow the Home CCO enrollment policy outlined in this rule, except when:

(a) The Home CCO enrollment hinders access to care or puts the client at potential harm, or the Home CCO is unable to provide needed unique services, a change in

enrollment may be requested for the member to a CCO serving the service area of the temporary out-of-area placement;

(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3080. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.

(8) Pursuant to OAR 410-141-3080, if the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO. If the individual was enrolled in a different CCO in error, the Authority shall disenroll the individual from the incorrect CCO and recoup the capitation payments, pursuant to OAR 410-120-1395. Re-enrollment to the correct CCO shall occur as specified in OAR 410-141-3060.

(9) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3080 shall apply. If the Authority determines that disenrollment should occur, the CCO shall continue to provide covered services until the disenrollment date established by the Authority, pursuant to 410-141-3160. This shall provide for an adequate transition to the next responsible coordinated care organization.

Stats. Auth.: ORS 413.042, 414.610 - 414.685

Stats. Implemented: ORS 413.042, 414.610 - 414.685

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 shall:

(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/12 LTEIRSDrugs.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 requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the 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 are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining formularies of drugs regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3080 – Disenrollment from Coordinated Care Organizations

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

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

(a) Without cause:

(A) Newly eligible members may change their CCO or DCO assignment within 12 months following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months;

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

(D) In accordance with ORS 414.645, members may disenroll from a CCO or DCO during their redetermination (enrollment period) or one additional time during their enrollment period based on the member's choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

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

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

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

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

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

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

(iv) As specified in ORS 414.645, the Authority may approve the transfer of 500 or more members from one CCO or DCO to another CCO or DCO if:

(I) The member’s provider has contracted with the receiving CCO or DCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO or DCO; and

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

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

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

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

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

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

(c) If the following conditions are met:

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

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

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

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

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

(B) Involuntary transfer of a member from a CCO or DCO to another CCO or DCO; or

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

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

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

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

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

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

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

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

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

(d) Because the member requests a hearing;

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

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

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

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

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

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

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

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

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

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

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

(F) If the severity of the problem warrants, the CCO or DCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO or DCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

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

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

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

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

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

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

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

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

(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO or DCO shall attempt to locate another PCP on their panel who will accept the member as their patient. If needed, the CCO or DCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO or DCO's policies and shall be consistent with CCO or DCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO or DCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

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

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

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

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

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

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

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

(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO or DCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

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

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

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

(I) Documentation shall exist that verifies the CCO or DCO's rationale for concluding that the member's continued enrollment in the CCO or DCO seriously

impairs the CCO or DCO's ability to furnish services to either this particular member or other members.

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

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

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

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

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

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

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

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

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will proceed unless the member requests continued enrollment, pending a decision:

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

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

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

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

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

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

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

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

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

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

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

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

(d) Excluding the DCOs, if the CCO determines that the member or MHO member has Third Party Liability (TPL), the CCO will contact the Health Insurance Group (HIG) to request disenrollment;

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

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

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

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

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

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

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

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

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

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

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

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

Stats. Implemented: ORS 414.610 - 414.685

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 contendre").

(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 (NPPES);

(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 410-120-1 580. 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

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

410-141-3150 – Other Non-Medical Services (T)

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

(2) In the conventional manner using CPT or HCPCS codes, Other Non-Medical Services cannot be reported for utilization purposes. CCOs report qualified Other Non-Medical Services to the Authority in the financial report category “health related services” referenced in the CCO contract and accounted for in the CCO’s medical or member services’ expenses. These expenditures are not counted as administrative costs when determining medical loss ratio. Other Non-Medical Services may include, but are not limited to:

(a) Training and education for health improvement or management, e.g., classes on healthy meal preparation, diabetes self-management curriculum;

(b) Self-help or support group activities, e.g., post-partum depression programs, Weight Watchers groups;

(c) Care coordination, navigation, or case management activities not covered under state plan benefits, e.g., high utilizer intervention program;

(d) Home and living environment items or improvements such as non-DME items to improve mobility, access, hygiene, or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes, or other special clothing;

(e) Transportation not covered under state plan benefits, e.g., other than transportation to a medical appointment;

(f) Programs to improve the general community health, e.g., farmers’ market in the “food desert;”

(g) Housing supports related to social determinates of health, e.g., shelter, utilities, or critical repairs; and

(h) Assistance with food or social resources, e.g., supplemental food, referral to job training or social services.

(3) The contractor shall establish and maintain written policies and procedures for authorizing Other Non-Medical Services. In compliance with the contractor’s policy, CCO-covered services may be substituted with or expanded to include Other Non-

Medical Services. These services shall be coordinated by the contractor and may be in collaboration with the PCPCH or other participating PCPs. The contractor, the member, and, as appropriate, the family of the member are to agree that such services are an effective alternative for the member. These policies and procedures shall be submitted to the Authority for review and approval.

Stat. Auth.: ORS 413.042

Stats Implemented: ORS 413.042

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 and follow up services for all members' 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) CCO's must assess the needs of its membership and make available supported employment and assertive community treatment services available when medically appropriate and when an appropriate provider is available. Appropriate providers are those that meet the requirements in 309-016-0825. When no appropriate provider is available, the CCO must consult with AMH and develop an approved plan to make supported employment and assertive community treatment services available.

(4) 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.

(5) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO shall ensure 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

(13) 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.

(14) 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.

(15) 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

410-141-3170 – Intensive Care Coordination (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 (when the CCO or DCO is responsible for dental care), mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.

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

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

(b) Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410- 141-0140;

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

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

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

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

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

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

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

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

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

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

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

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

Stats. Implemented: ORS 414.610 – 685

410-141-3260 – 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 a Division 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 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 healthcare 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 have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) Appeal forms;

(c) Hearing request form (DHS 443) and Notice of Hearing Rights (DMAP 3030); or

(d) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form (DMAP 3302) or approved facsimile.

(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 for good cause, as defined in OAR 137-002-0528, 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.

(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

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

Stats. Implemented: ORS 414.610 – 414.685

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 CCO Appeal

(1) A member, their representative or a subcontractor/provider, with the member's consent, who disagrees with a notice of action (notice) has the authority to file an appeal with their CCO.

(2) For purposes of this rule, an appeal includes a request from the Division to the CCO for review of action.

(3) The member may request an appeal either orally or in writing directly to their CCO for any action by the CCO unless the member requests an expedited resolution, the member must follow an oral filing with a written, signed and dated appeal. If the member files an oral appeal, the CCO must send the member an appeal request form.

(4) The member must file the appeal no later than 45 calendar days from the date on the notice.

(5) The CCO must have written policies and procedures for handling appeals that:

(a) Address how the CCO will accept, process and respond to such appeals, including how the CCO will acknowledge receipt of each appeal;

(b) Ensure that members who receive a notice are informed of their right to file an appeal and how to do so;

(c) Ensure that each appeal is transmitted timely to staff having authority to act on it;

(d) Consistent with confidentiality requirements, ensure that the CCO's staff person who is designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt of the appeal;

(e) Ensure that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensure that the individuals who make decisions on appeals are:

(A) Not involved in any previous level of review or decision making; and

(B) Health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if an appeal of a denial is based on lack of medical appropriateness; or if an appeal involves clinical issues.

(g) Include a provision that the CCO must document appeals in an appeals log maintained by the CCO that complies with OAR 410-141-3260 and consistent with contractual requirements.

(h) Ensure oral requests for appeal an action are treated as appeals to establish the earliest possible filing date for the appeal; and

(i) Ensure the member is informed that the member must in writing unless the person filing the appeal requests expedited resolution;

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

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

(6) Parties to the appeal Include:

(a) The CCO;

(b) The member and the member's representative, if applicable;

(c) The legal representative of a deceased member's estate.

(7) The CCO must resolve each appeal and provide the member and their representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within the following periods for:

(a) Standard resolution of appeal: no later than 16 calendar days from the day, the CCO receives the appeal;

(b) Expedited resolution of appeal (when granted by the CCO): no later than three working days from the date the CCO receives the appeal. In addition, the CCO must:

(A) Inform the member and their representative of the limited time available;

(B) Make reasonable efforts to call the member to tell them of the resolution within three calendar days after receiving the request; and

(C) Mail written confirmation of the resolution to the member within three calendar days.

(c) In accordance with 42 CFR 438.408, the CCO may extend these timeframes from subsections (a) or (b) of this section up to 14 calendar days if:

(A) The member or their representative requests the extension; or

(B) The CCO shows (to the satisfaction of the Division's Hearing Unit, upon its request) that there is need for additional information and how the delay is in the member's interest.

(C) If the CCO extends the timeframes, it must for any extension not requested by the Member, give the Member or their representative written notice of the reason for the delay.

(8) For all appeals, the CCO must provide written notice of appeal resolution to the member and also to their representative when the CCO knows there is a representative for the member.

(9) The written notice of appeal resolution must include the following information:

(a) The results of the resolution process and the date the CCO completed the resolution; and

(b) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the CCO from the Division as part of a contested case hearings process, the right to request a hearing and how to do so;

(C) The right to request to receive benefits while the hearing is pending and how to do so; and

(D) That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCO's Action.

(10) Unless the appeal was referred to the CCO as part of a contested case hearing process, a member may request a hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution.

(11) If the appeal was referred to the CCO from the Division as part of a contested case hearing process, within two business days from the date of the appeal resolution, the CCO must transmit the:

(a) Notice of Appeal Resolution; and

(b) Complete record of the appeal to the Division's Hearings Unit.

(12) If the appeal was made directly by the member or their representative, and the Notice of Appeal Resolution was not favorable to the member, the CCO must, if a contested case hearing is requested, submit the record to the Division's Hearings Unit within two business days of the Division's request.

(13) Documentation:

(a) The CCO's records must include, at a minimum, a log of all appeals received by the CCO and contain the following information:

(A) Member's name and Medical Care ID number;

(B) Date of the Notice;

(C) Date and nature of the appeal;

(D) Whether continuing benefits were requested and provided; and

(E) Resolution and resolution date of the appeal.

(b) The CCO must maintain a complete record for each appeal included in the log for no less than 45 days to include:

(A) Records of the review or investigation; and

(B) Resolution, including all written decisions and copies of correspondence with the member.

(c) The CCO must review the written appeals log on a monthly basis for:

(A) Completeness;

(B) Accuracy;

(C) Timeliness of documentation;

(D) Compliance with written procedures for receipt, disposition and documentation of appeals; and

(E) Compliance with OHP rules.

(d) The CCO must address the analysis of appeals in the context of quality improvement activity consistent with OAR 410-141-3200 OHP CCO Quality Improvement System and 410-141-3260 General Requirements for CCO Grievance System;

(e) The CCO must have written policies and procedures for the review and analysis of all appeals received by the CCO. The analysis of the grievance system must be reviewed by the CCO's Quality Improvement Committee consistent with contractual requirements and comply with the quality improvement standards.

Stat. Auth.: ORS 414.032

Stats. Implemented: ORS 414.065

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 specific 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 how to request one; 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;

(d) The Notice of Action must be on a Division approved form.

(2) The CCO must include the appropriate forms based on the Division approved Notice of Action, as outlined in OAR 410-141-3260, to the notice.

(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 probable 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) In accordance with 42 CFR 438.408, the CCO may extend the timeframes from (5) above by up to 14 calendar days, if:

(a) The Division member or Division member's representative requests the extension; or

(b) The CCO shows (to the satisfaction of the Division's Hearings Unit upon it request) that there is need for additional information and how the delay is in the Division member's interest.

(8) If the CCO extends the timeframes, it must, for any extension not requested by the Division member, give the Division member and Division member's representative, a written notice of the reason for the delay.

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), 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 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.

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

410-141-3267 – Process for Resolving Disputes between Coordinated Care Organizations (CCOs) and the Oregon Health Authority (T)

For purposes of this rule:

(1) “Party” means a CCO taking one side of a question or dispute.

(2) In the event of a dispute with the Oregon Health Authority (Authority) initiated by a CCO, the CCO shall use the Division’s Administrative Review process as specified in OAR 410-120-1580. If the dispute is likely to impact another CCO, the Authority will notify all CCOs potentially impacted by the dispute and provide an opportunity for the impacted CCOs to participate in the dispute as a party. The Authority shall maintain the confidentiality of proprietary information of a CCO to the extent such information is protected under state or federal law if more than one CCO is involved in the dispute and the dispute involves a subject necessitating the use of proprietary information.

(3) An administrative review, for purposes of this rule, allows the opportunity for the director of the Division of Medical Assistance Programs (Division) or their designee to review a dispute affecting the CCO under the procedures set forth in OAR 410-120-1580. Examples of such disputes may include, but are not limited to, contract compliance disputes, service area changes, and the Authority decisions made through the OHA Provider Discrimination Review Process as a result of a provider discrimination appeal. These disputes primarily address legal or policy issues that may arise in the context of a Division decision that is perceived by the CCO to adversely affect the CCO and is not otherwise reviewed as a claim redeterminaton, a contested case, or client appeal.

(4) The Division shall send written results of the administrative review to the CCO initiating the dispute and any other impacted party within 30 calendar days of the conclusion of the administrative review proceeding, or such other time as may be agreed to by the parties and the Division.

(5) The Division’s final decision on administrative review is the final decision of the Authority on the dispute and is binding on the parties. The decision is an order in other than a contested case. Judicial appeal of the decision is subject to ORS 183.484 and the procedures set forth in OAR 137-004-0080 to 137-004-0092.

Stat. Auth: ORS 183.484, ORS 413.042

Stats. Implemented: ORS 183.484, ORS 413.042

410-141-3268 – Process for Resolving Disputes on Formation, Certification, and Recertification of CCOs

(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 a 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 shall take the following actions in an attempt to reach a good faith resolution:

(A) The applicant shall provide a written offer of terms and conditions to the HCE. The HCE shall 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 shall 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) Pursuant to 2013 Engrossed SB 568 and 2013 Oregon Laws chapter 27, if the applicant and HCE cannot reach agreement on contract terms within ten calendar days of the face-to-face meeting, either party may request arbitration. The requesting party shall notify the other party in writing to initiate a referral to an independent third party arbitrator for an HCE's refusal to contract with the CCO or the termination, extension, or renewal of a HCE's contract with a CCO. The party initiating the referral shall 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 ten calendar days of a referral to an arbitrator, the applicant and HCE shall submit to each other and to the arbitrator the following:

(a) The 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 shall submit to the arbitrator and the other party the 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 an 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 Health Services Transformation (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 cannot reasonably meet without significant negative impact on HCE costs, obligations, or structure while considering the proposed reimbursement arrangement or other CCO requirements. Some of the requirements include:

(i) Use of electronic health records;

(ii) Service delivery requirements, or

(iii) 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 shall 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 shall 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 ten 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 tenth day, the arbitrator may not release the determination to the Authority;

(c) If the parties have not reached an agreement after ten calendar days, the arbitrator shall 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 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 shall:

(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 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

410-141-3269 – Process for Resolving Contract Disputes Between Health Care Entities and Coordinated Care Organizations

(1) Pursuant to ORS 414.635, Coordinated Care Organizations (CCOs) and Health Care Entities (HCE) shall participate in good faith contract negotiations. This rule covers the termination, extension, and renewal of an HCE's contract with a CCO.

(2) In the event of a dispute involving the termination, extension, or renewal of an HCE's contract with a CCO, the parties may take the following actions in an attempt to reach a good faith resolution:

(a) Both parties shall provide a written offer of terms and conditions to the other party. The parties shall explain the basis for their disagreement with the terms and conditions offered by the other party;

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

(c) The CCO or HCE may request the Authority to provide technical assistance. The Authority's technical assistance is limited to clarifying the CCO contractual provisions, subcontracting criteria, current reimbursement requirements, access standards, and other legal requirements.

(3) If the CCO and HCE cannot reach agreement on contract terms, the parties may engage in mediation. Either the CCO or the HCE may request mediation:

(a) After the parties have agreed to enter into mediation, the parties shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the parties are unable to agree, each party shall appoint a mediator, and those mediators shall select the final mediator;

(b) To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(A) Be a knowledgeable and experienced mediator;

(B) Be familiar with health care and contracting matters; and

(C) Follow the terms and conditions specified in this rule for the mediation process.

(c) The parties shall pay for all mediation costs, whether a conclusion is reached or not. 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 mediator to allocate costs between the parties based on the ability to pay;

(d) Within ten business days of a selection of a mediator, the CCO and HCE shall submit to each other and to the mediator the following:

(A) Contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) Unless an extension is agreed on by all parties, the mediator shall issue a report to the involved parties that will include mediation findings and recommendations no longer than 15 business days from the conclusion of the mediation.

(4) Pursuant to ORS 414.635, if the CCO and HCE cannot reach an agreement on contract terms within ten business days of receipt of the mediator's report, either party may request non-binding arbitration. The requesting party shall notify the other party in writing of the party's intent to refer the matter to arbitration:

(a) After notification that one party initiated arbitration, the parties shall agree on 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;

(b) To be qualified to propose resolutions for disputes under this rule, the arbitrator shall:

(A) Be a knowledgeable and experienced arbitrator;

(B) Be familiar with health care provider contracting matters; and

(C) Follow the terms and conditions specified in this rule for the arbitration process.

(c) 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;

(d) Within ten business days of a selection of an arbitrator, the CCO and HCE shall submit to each other and to the arbitrator the following:

(A) Final contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) The arbitrator shall evaluate the final offers and the advocacy briefs from each party and issue a non-binding determination within 15 business days of the receipt of the parties' submissions.

Stat. Auth.: ORS 414.042, 414.615, 414.625, 414.635 and 414.651

Stats. Implemented: ORS 414.610 – 414.685

410-141-3270 – Coordinated Care Organization Marketing Requirements for Potential Members

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

(a) “Cold-call Marketing” means any unsolicited personal contact with a potential member for the purpose of marketing by the CCO.

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

(c) “Marketing Materials” means materials that are produced in any medium by or on behalf of a CCO and that can reasonably be interpreted as intended to market to potential members.

(d) “Outreach” means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO’s subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.

(e) “Outreach Materials” means materials that are produced in any medium, by or on behalf of a CCO that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO.

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

(2) CCOs shall comply with 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the CCO provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that CCO. CCOs shall distribute the materials to its entire service area as indicated in its CCO contract. The CCOs may not:

(a) Distribute any marketing materials without first obtaining state approval;

(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and

(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The following communications are expressly permitted:

(a) The creation of name recognition and communication methodologies may include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(b) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(4) CCOs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm information before posting.

(5) CCOs have sole accountability for producing or distributing materials following Authority approval.

(6) CCOs shall comply with the Authority marketing materials submission guidelines. CCOs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with CCO marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

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

Stats. Implemented: ORS 414.610 – 685

410-141-3280 – Coordinated Care Organization (CCO) Potential Member Information Requirements

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

(a) “Alternate Format” means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

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

(c) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO’s total OHP enrollment; or

(B) 1,000 of the CCO’s members;

(d) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270; Oregon Health Plan Marketing Requirements.

(3) 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.

(4) A CCO or its subcontractor’s communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client’s enrollment.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align CCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with providers’ service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) CCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) CCOs shall develop informational materials for potential members.

(8) CCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The CCO shall make available to potential members, upon request, information on participating providers.

(9) CCO provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. A CCO or the Division may include informational materials in the application packet for potential members.

(10) CCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) CCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) CCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) CCOs shall ensure that all CCO staff who have contact with potential members are fully informed of CCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, and the availability of free certified health care interpreters, and which participating providers' offices have bilingual capacity and which are accepting new members.

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

Stats. Implemented: ORS 414.610 – 414.685

410-141-3300 – Coordinated Care Organization (CCO) Member Education and Information Requirements

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

(a) “Alternate Format” means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) “Alternate Format Statement Insert” means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state’s top sixteen preferred written languages as identified by OHP enrollees. CCOs shall insert their contact information into the template.

(c) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(d) “Prevalent Non-English Language” means: All non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO’s total OHP enrollment; or

(B) 1, 000 of the CCO’s members.

(2) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall 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 requirements for obtaining coordinated care services at service area sites or benefits.

(3) 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, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(4) 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.

(5) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers' service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) 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 shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(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 and include information to members that interpreter services at provider offices are free to CCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO twelve months or more after previous enrollment. The

packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients.

(11) For those who are existing members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request.

(12) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes;

(b) Alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit;

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services;

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large type, and braille.

(13) A CCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille.

(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. Explain how to choose a PCP, how to make an appointment, and how to change PCPs 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 participating or non-participating provider services the member may self-refer;

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

(h) Explanation of intensive care coordination services and how members with the following special health care needs can access intensive care coordination services: Those who are aged, blind, or disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency.

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

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

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

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

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

(n) Information on the CCO's grievance and appeals processes and the Division'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 OAR 410-141-3260;

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

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

(p) 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; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

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

(s) Information on advance directive policies including:

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

(B) The 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;

(t) Whether or not the CCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

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

(w) Resources for help with transportation to appointments with providers;

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

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

(z) The CCO's confidentiality policy;

(aa) 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;

(bb) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;

(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.

(14) 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. CCO 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 and linguistically appropriate 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 Division may assist in developing materials

that address specifically identified health education problems to the population in need;

(c) Explanation of intensive care coordination services 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 member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, 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 Division shall review and approve the materials within two working days.

(15) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) CCOs shall provide free interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care:

(A) CCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(B) CCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language;

(b) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent

in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

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

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

Stats. Implemented: ORS 414.610 – 414.685

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 – General Financial Reporting and Financial Solvency Matters; Transition

(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 to 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 shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule and under 410-120-1280.

(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, if a valid DMAP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; 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. Before providing a non-covered service, the provider must complete a DMAP 3165, or facsimile, as described in OAR 410-120-1280.

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), 65, HB 3650

410-141-3420 – Billing and Payment

(1) Providers shall submit all billings for CCO members in the following timeframes:

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

(A) Pregnancy;

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

(C) Medicare is the primary payer, except where the 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 the provider to certify the member's eligibility; or

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

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

(2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Authority'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, shall 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's tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete a DMAP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(5) CCOs shall pay for all covered coordinated care services. These services shall 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 written procedures for processing preauthorization requests received from any provider and written procedures for processing claims submitted from any source. The procedures shall specify time frames for:

(A) Date stamping preauthorization requests and claims when received;

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

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

(D)The specific number of days following receipt of the additional information that a redetermination shall 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 percent 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 shall be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO shall 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 two 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 shall 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 as outlined in OAR 410-141-3263. CCOs shall 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 member's best interest. If the CCO extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 410-141-3263. 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;

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

(f) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3263;

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

(h) 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;

(i) 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;

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

(7) 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.

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

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

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

(b) The covered service was delivered in good faith without the preauthorization; and

(c) It was a covered service that would have been preauthorized 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 that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies, including but not limited to pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. CCOs shall attest annually to the Authority in a manner to be prescribed to CCO’s compliance with these requirements.

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

(a) Sections (10) – (12) only apply to services provided by Type A or Type B hospitals to clients or members that are enrolled in a CCO;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require CCOs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals transitioning from CBR to an APM, the Authority shall require hospitals and CCO’s to enter into good faith negotiations for contracts to be effective by January 1, 2015. Dispute resolution during the

contracting process shall be subject to OAR 410-141-3268 and 410-141-3269, as applicable;

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

(11) Redetermination of which Type A or Type B hospitals shall transition off of CBR:

(a) No later than April 30, 2015, the Authority shall update the algorithm for calculation of the CBR methodology with the most recent data available;

(b) After recalculation for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1, 2016;

(c) The Authority shall recalculate the reimbursement methodology for each hospital every two years thereafter;

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

(12) Non-contracted Type A or Type B hospital rates for those transitioning off of CBR:

(a) Charges shall be discounted for both inpatient and outpatient services. The initial reimbursement rate effective January 1, 2015 shall be based on the individual hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(b) Reimbursement rates effective for the calendar year beginning January 1, 2016 shall be based on the hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services and further adjusted by the Actuarial Services Unit (ASU) based on the individual hospital's annual price increases during FY 2014 – FY 2015 and the Authority's global budget rate increase as defined by the CMS 1115 waiver, using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

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

(d) ASU shall contact hospitals regarding price increases during March of each year;

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

(f) A volume adjustment shall be applied. ASU shall develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority shall determine when the volume adjustment might sunset on a hospital specific basis;

(g) Non-contracted Type A or Type B hospital reimbursement rates for those transitioning off of CBR can be found in the Rate Table section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

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

(a) Certain services shall 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 shall verify a member's eligibility using the web portal or AVR;

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

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

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

(e) The Authority may not pay a provider for providing services for which 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 that 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).

(14) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 (Excluded Services and Limitations for OHP Clients).

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.065 and 414.610 through 414.685

410-141-3430 - Coordinated Care Organization Encounter Claims Data Reporting

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

(2) CCOs must collect service information in standardized formats to the extent feasible and appropriate, if HIPAA standard, the CCO must utilize the HIPAA standards.

(a) CCOs shall submit encounter claims for all services, whether they are flexible services or covered services, provided to members as defined in OAR 410-120-0000 and 410-141-0000.

(b) CCOs shall submit encounter claims data including encounters for services where the CCO determined that:

(A) Liability exists;

(B) No liability exists even if the CCO did not make any payment for a claim;

(C) Including claims for services to members provided by a provider under a subcontract, capitation or special arrangement with another facility or program; and

(D) Including paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the CCO, or the CCO's subcontractor.

(c) CCOs shall submit encounter claims data for all services to members who also have Medicare coverage, if a claim has been submitted to the CCO.

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

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

(4) CCOs must submit encounter claims in the time frames as described below for the following claim types:

(a) Non-pharmacy encounter claims; professional, dental, and institutional;

(A) CCOs must submit encounter claims at least once per month for no less than 50% of all claim types received and adjudicated that month;

(B) CCOs must submit all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service except as may be applicable in paragraph (C) below;

(C) CCOs may only delay submission of encounter claims within 180 days from the date of service with prior notification to the Authority and only for any of the following reasons:

(i) Member's failure to give the provider necessary claim information;

(ii) Resolving local or out-of-area provider claims;

(iii) Third-Party Resource liability or Medicare coordination;

(iv) Member''s pregnancy;

(v) Hardware or software modifications to CCO's health information system, or;

(vi) Authority recognized system issues preventing timely submission or correction of encounter claims data.

(b) Pharmacy claims:

(A) CCOs must ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP), as available on their web site http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization;

(B) All pharmacy encounter claims data must be submitted by the CCO, whether by the CCO's pharmacy benefit manager or the CCO's subcontractor at least once a month for all services received and adjudicated that month and must submit all remaining unreported CCO pharmacy encounter claims within 60 days from the date of service.

(c) Submission Standards and Data Availability:

(A) CCOs must only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the CCO by the Authority in encounter claims;

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

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

(B) CCOs must make an adjustment to any encounter claim when the CCO discovers the data is incorrect, no longer valid or some element of the claim not identified as part of the original claim needs to be changed;

(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) below, the CCO must adjust or void the encounter claim within 14 calendar days of notification by the Authority of the required action or as identified in paragraph (E) below;

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

(E) If circumstances prevent the CCO from meeting requested time frames for correction the CCO may contact the Authority to determine an agreed upon specified date except as required in subsection (d) below;

(F) CCOs must ensure claims data received from providers, either directly or through a third party submitter, is accurate, truthful and complete by:

(i) Verifying accuracy and timeliness of reported data;

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

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

(H) CCOs must make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.

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

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

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

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

(D) CCOs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the CCO notice that the encounter claim remains in a "must correct" status.

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

(5) Enrollment of providers included on an encounter claim.

(a) CCOs shall ensure that all providers are enrolled with the Authority prior to submission of the encounter claim as either;

(A) An Oregon Medicaid fee for service provider or

(B) A provider that is not a fee for service provider but does provide services to the CCO’s enrolled members, and

(C) CCOs must ensure the provider is not excluded per federal and state standards as set forth in OAR 943-120-0100 through 943-120-0200 and as specified in 42 CFR 455.400 through 455.400.

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

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

(b) CCOs must respond within the time frame determined by the Authority to any request for:

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

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

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

(a) CCOs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of the date of service or

(b) Immediately upon notification by the Authority that a qualifying encounter claim has been identified;

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

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

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

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

(8) Upon request by the Authority, CCOs must furnish information regarding rebates for any covered outpatient drug provided by the CCO, as follows:

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

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

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

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

(A) By notifying the Authority that the CCO agrees an error has been made, and

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

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

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

410-141-3435 – NEMT General Requirements

(1) A Coordinated Care Organization shall provide all NEMT services for its members. The Authority shall provide NEMT services in CCO's service area only to members not enrolled in a CCO.

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

(3) A CCO and its contracted transportation provider may not bill a member for any transport to and from medical services that are covered and where the CCO or its contracted transportation provider denied reimbursement.

(4) CCOs shall require NEMT providers to obtain and maintain insurance at limits no less than is required under OAR 410-136-3060.

(5) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3180 (Record Keeping and Use of Health Information Technology).

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3440 – Vehicle Equipment and Driver Standards

(1) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR Chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

(2) The CCO shall require all vehicles used for NEMT services to meet the following requirements for the comfort and safety of the members:

(a) The interior of the vehicle shall be clean and free from any debris impeding a member's ability to ride comfortably;

(b) Smoking is prohibited in the vehicle at all times in accordance with ORS 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and

(c) The transportation provider shall comply with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) First aid kit;

(C) Fire extinguisher;

(D) Roadside reflective or warning devices;

(E) Flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to transport members using wheelchairs or stretchers, if the member is using a wheelchair or stretcher.

(3) A preventative maintenance schedule shall be followed for each vehicle that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to, the following equipment:

(a) Side and rear view mirrors;

(b) Horn; and

(c) Working turn signals, headlights, taillights, and windshield wipers.

(4) Prior to hiring an NEMT driver, the CCO shall require the following:

(a) The driver must have a valid driver license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and

(b) The driver must pass a criminal background check in accordance with ORS 181.534, ORS 181.537, and OAR chapter 257, division 10. If the driver is employed by a mass transit district formed under ORS chapter 267, the driver must pass a criminal background check in accordance with ORS 267.237 as well as the mass transit district's background check policies. A CCO shall have an exception process to the criminal background check requirement that may allow approval of a driver with a criminal background under certain circumstances. The exception process must include review and consideration of when the crime occurred, the nature of the offense, and any other circumstances to ensure that the member is not at risk of harm from the driver. Any approvals made through the exception process must be documented and maintained for three calendar years, even if the CCO is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) Drivers authorized to provide NEMT services must receive training on their job duties and responsibilities including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting, and the geographic area in which drivers will provide service;

(b) Completing the National Safety Council Defensive Driving course or equivalent within six months of the date of hire and at least every three years thereafter;

(c) Completing Red Cross-approved First Aid, Cardiopulmonary Resuscitation and blood spill procedures courses or equivalent within six months of the date of hire and maintain the certification;

(d) Completing the Passenger Service and Safety course or equivalent course within six months of the date of hire and at least every three years thereafter; and

(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride.

(6) For authorized out-of-state NEMT services in which the transportation provider solely performs work in the other state and for which the CCO has no oversight

authority, the CCO is not responsible for requiring that the subcontractor's vehicle and standards meet the requirements set forth in this rule.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3445 – Out-of-Service-Area and Out-of-State Transportation

(1) A CCO shall provide NEMT services outside the CCO's service area under the following circumstances:

(a) The member is receiving an OHP-covered health care service that is not available in the service area but is available in another area of the state;

(b) The member is receiving an OHP-covered service where the service location is no more than 75 miles from the Oregon border and contiguous to the CCO's service area;

(c) The CCO determines that no local medical provider or facility as outlined in OAR 410-141-3220 will provide OHP-covered medical services for the member; or,

(d) The member is receiving an OHP-covered service outside of Oregon that is not available in Oregon.

(2) Nothing in this rule prohibits a CCO from providing and paying for NEMT services to allow a client to access other services the CCO authorizes.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3450 – Attendants for Child and Special Needs Transports

(1) This rule applies to NEMT for children under 12 years of age who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to children and young adults with special physical or developmental needs regardless of age.

(2) Parents or guardians must provide an attendant to accompany these members while traveling to and from medical appointments except when:

(a) The driver is a Department of Human Services (Department) volunteer or employee or an Authority employee;

(b) The member requires secured transport pursuant to OAR 410-141-3437 (Secured Transports); or

(c) An ambulance provider transports the member for non-emergent services, and the CCO reimburses the ambulance provider at the ambulance transport rate, per CCO contract or non-contracted rate policy.

(3) NEMT ambulance transports shall have an attendant when the CCO uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) The Department shall establish and administer written guidelines for members in the Department's custody including written guidelines for volunteer drivers. If the Department's requirements or administrative rules differ from this rule, the Department's requirements or administrative rules take precedence.

(5) An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant may also be any adult the parent or guardian authorizes. An attendant may also be the member's brother, sister, stepbrother, or stepsister if the attendant is at least 18 years of age, and the parent or guardian authorizes it.

(6) CCOs may require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.

(7) The CCO may not bill additional charges for a member's attendant.

(8) The attendant must accompany the member from the pick-up location to the destination and the return trip. The attendant must also remain with the member during their appointment.

(9) The member's parent, guardian, or adult caregiver shall provide and install safety seats as required by ORS 811.210 - 811.225. An NEMT driver may not transport a

member if a parent or guardian fails to provide a safety seat that complies with state law.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3455 – Secured Transports

(1) “Secured transport” means NEMT services for the involuntary transport of members who are in danger of harming themselves or others. Secured transports may be used when:

(a) The CCO verified that the secured transporter has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through OAR 309-033-0970, and the secured transporter is able to transport the member who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the member in crisis.

(2) One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

(3) The CCO shall authorize transports to and from OHP covered medical services for an eligible member for court ordered medical services with the following exceptions:

(a) The member is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The member is an inmate of a public institution as defined in OAR 461-135-0950 (Eligibility for Inmates); or

(c) The Authority has suspended the member’s OHP eligibility pursuant to ORS 411.443 or ORS 411.439.

(4) The CCO shall assume that a member returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a member to their place of residence, the CCO shall obtain written documentation signed by the treating medical professional stating the circumstances that required secured transport. The CCO shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The CCO may approve and pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing if there is no other source of funding for this transport.

(6) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3460 – Ground and Air Ambulance Transports

(1) Transporting a member via ambulance is required when a medical facility or provider states the member's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the CCOs shall authorize the transport.

(3) CCOs shall provide ambulance transports with a medical technician when:

(a) A member's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The member does not have an attendant who can assist with personal care during the ride.

(4) When a member's medical condition is an emergency as defined in OAR 410-120-0000, emergency ambulance transportation must be used. The ambulance must transport the member to the nearest appropriate facility able to meet the member's medical needs.

(5) CCOs shall verify that the Authority has licensed providers of ground or air ambulance services to operate ground or air ambulances. If the ambulance service provider is located in a contiguous state and regularly provides rides to OHP members, the CCO must ensure that both the Authority and the contiguous state have licensed the ambulance service provider.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3465 – Modifications for Individuals with Disabilities

(1) For the purposes of this rule, “direct threat” means a significant risk to the health or safety of others. A direct threat is one that:

(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes.

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence that shows:

(A) The nature, duration, and severity of the risk;

(B) The probability that a potential injury will actually occur; and

(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.

(2) CCO’s may not apply criteria, standards, or practices that screen out or tend to screen out individuals in a protected class from fully and equally enjoying any goods, services, programs, or activities unless:

(a) The criteria can be shown to be necessary for providing those goods and services; or

(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.

(3) CCOs and their subcontractors shall comply with the Authority’s non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.

(4) CCO members may use the processes and rights specified in OAR 410-141-3260 through 3264 (Grievance System and Contested Case Hearings Rules).

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3470 – Service Modifications

(1) CCOs shall draft policies and procedures describing passenger rights and responsibilities including the right to file a complaint and request reconsideration and provide this information in all general information materials such as handbooks.

(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles and provide the information to contractors, subcontractors, and members receiving NEMT services.

(3) A CCO may modify or a member may request modification of NEMT services when the member:

(a) Threatens harm to the driver or others in the vehicle.

(b) Has a health condition that creates a health or safety concern to the driver, others in the vehicle, or the member as described in OAR 410-141-3439.

(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm.

(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services.

(e) Frequently does not show up for scheduled rides.

(f) Frequently cancels the ride on the day of the scheduled ride time.

(4) Reasonable modifications include, but are not limited to, requiring members to:

(a) Use a specific transportation provider;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive or locate someone to drive the member and receive mileage reimbursement;

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(5) Before modifying services, the NEMT provider, a CCO representative, and the member shall:

(a) Communicate about the reason for imposing a modification;

(b) Explore options that are appropriate to the member's needs;

(c) Address health and safety concerns;

(d) The CCO or member may include the member's care team in the discussion;

(e) The member may include another individual of their choosing in the discussion.

(6) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.

(7) A CCO may not modify NEMT services under this rule due solely to a request for modification or auxiliary aid based on disability or other protected class status.

(8) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.

(9) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3475 – Contested Case Hearings

As required by 42 CFR 431, the CCO shall comply with OAR 410-141-3264 pertaining to contested case hearings when it denies a ride with the following exceptions:

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

(2) The CCO shall mail a notice of action to a member denied a ride within 72 hours of denial.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3480 – Member Reimbursed Mileage, Meals, and Lodging

(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.

(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.

(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. See the Division's fee schedule, available at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(4) The member must return any documentation a CCO requires before receiving reimbursement.

(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.

(6) A CCO shall reimburse members for meals when a member travels:

(a) Out of their local area as outlined in OAR 410-141-3220 (4) (a) and (b); and

(b) For a minimum of four hours round-trip.

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.

(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.

(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:

(a) The member is a minor child and unable to travel without an attendant;

(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;

(c) The member is mentally or physically unable to reach his or her medical appointment without assistance; or

(d) The member is or would be unable to return home without assistance after the treatment or service.

(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCOs discretion.

(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The member; or

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;

(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.

(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625

410-141-3485 – Reports and Documentation

(1) CCOs shall maintain documentation of rides denied and rides provided to members.

(2) For NEMT services provided to members, this documentation shall include:

(a) All encounter data required in the current CCO contract;

(b) Names of the company and driver transporting the member.

(3) For NEMT services denied to members, this documentation shall include:

(a) The name of the member and the individual requesting the ride on behalf of the member, if applicable;

(b) The member's OHP medical care identification number;

(c) The date and time of the request for transportation;

(d) The name of the employee who denied a ride;

(e) The name of the employee who performed the secondary review before denying the ride;

(f) The reason for the denial and the applicable OAR supporting the denial;

(g) The date on the notice of action the brokerage mailed to the member;

(h) Documentation on the review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

(i) Notations of oral and written communications with the member.

(4) The CCO shall retain the documentation on NEMT service denials for three calendar years, even if the CCO, its brokerage, or subcontractor that denied the service is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) The Authority may request and the CCO shall provide other reports or information not specified in sections (1-4) of this rule.

Stat. Auth.: ORS 413.042 and 414.625

Stats. Implemented: ORS 414.625